Monroe County Group Health Plan Document

Board of County Commissioners
Clerk of the Circuit Court
Land Authority
Property Appraiser
Sheriff's Office
Supervisor of Elections
Tax Collector

EFFECTIVE JANUARY 1, 2010

The Monroe County Group Health Plan (the Plan) was established by the Monroe County Board of County Commissioners (BOCC). The Plan includes the Eligible Employees, Eligible Retirees and Eligible Dependents of the following Monroe County Employers: the BOCC, Clerk of the Circuit Court, Land Authority, Property Appraiser, Sheriff's Office, Supervisor of Elections and Tax Collector. The Plan's Claims Administrator is Wells Fargo Third Party Administrator (Wells Fargo TPA) and Monroe County Board of County Commissioners (BOCC) is the Plan Administrator.

The Plan provides a combination of three preferred provider organization networks (PPO) and traditional benefits programs: Keys Physician-Hospital Alliance, or KPHA, in Monroe County; Dimension Plus in Miami-Dade, Broward, Palm Beach and Monroe Counties; and the MultiPlan/PHCS Network everywhere else in the nation. Under the Plan, Covered Plan Participants may receive greater benefits when obtaining Covered Services from a PPO network provider; however, benefits are provided for Covered Services when rendered by a non-PPO network provider, although generally at higher prices in non-emergency cases. Covered Plan Participants are free to select any health care Provider; however, benefits under the Plan will pay for Covered Services rendered by a Provider who is recognized for payment by the Monroe County Group Health Plan Document at the time the Covered Plan Participant receives Health Care Services.

To find out about a health care Provider's participation status, a Covered Plan Participant may review any of the Plan's Preferred Provider Organization Network Directories in effect by calling the Benefits Office at 305-292-4579 or the Keys Physician-Hospital Alliance (KPHA) at 305-294-4599 or 1-800-400-0984. Covered Plan Participants can also visit our web-site at http://monroecofl.virtualtownhall.net/Pages/MonroeCoFl_GroupInsurance/index.

Please carefully review the Schedule of Benefits which is a part of the Monroe County Group Health Plan Document for a detailed list of financial responsibilities. This is important because financial responsibilities, including any applicable Deductibles and Coinsurance responsibilities, *will* vary depending upon the Providers choosen.

This Monroe County Group Health Plan Document supersedes all other Monroe County Group Health Plan Documents and amendments and shall be the sole document used in determining benefits for which Covered Plan Participants are eligible. The Monroe County Group Health Plan Document may be amended from time to time by the Monroe County Board of County Commissioners, in its sole discretion, to reflect changes in benefits, eligibility requirements, plan participant contributions, or changes in the law. It is not in lieu of and does not affect any requirements for coverage by Workers' Compensation.

It is the responsibility of each Covered Plan Participant to understand their benefits, rights and obligations under the Monroe County Group Health Plan Document. For questions or language clarification contact the Benefits Office at 305-292-4579.

General Plan Information

TYPE OF ADMINISTRATION

The Plan is a self-funded employee group health plan. Claims administration is provided through a Third Party Claims Administrator and prescription coverage through a Pharmacy Benefits Manager. The funding for these benefits is derived from the funds of the Employers and contributions made by the Covered Plan Participants.

PLAN NAME: MONROE COUNTY GROUP HEALTH PLAN

PLAN NUMBER: 5830

TAX ID NUMBER: 59-6000749

PLAN REVISION DATE: 01/01/10

PLAN YEAR ENDS: 12/31

EMPLOYERS:
Monroe County Board of County Commissioners
Clerk of the Circuit Court
Land Authority
Property Appraiser
Tax Collector
Supervisor of Elections
Monroe County Sheriff's Office

PLAN ADMINISTRATOR:
Monroe County Board of County Commissioners
Benefits Office
1100 Simonton Street, Suite 2-268
Key West, FL 33040
Lower Keys: (305) 292-4446
Middle Keys: (305) 743-0079
Upper Keys: (305) 852-1469

CLAIMS ADMINISTRATOR:
Wells Fargo Third Party Administrators, Inc. (TPA)
P. O. Box 3262
Charleston, WV 25332
(800) 624-8605

PHARMACY BENEFIT MANAGER:
Walgreens Health Initiatives, Inc.
P. O. Box 545
Deerfield, IL 60015
Customer Care Center: 1-800-207-2568
World Wide Web: www.mywhi.com

CERTIFICATION:
Keys Physician-Hospital Alliance (KPHA)
P. O. Box 9107
Key West, FL 33041
(305) 294-4599 or (800) 400-0984

Table of Contents

Section 1 - Schedule of Benefits

Covered Plan Participants should carefully review this Schedule of Benefits. The Plan provides coverage for adult wellness services without having to satisfy a Calendar Year Deductible requirement. Financial responsibilities, including any applicable Deductible and Coinsurance responsibilities **will vary** depending upon the Providers chosen by the Covered Plan Participant.

A. Deductible and Coinsurance Amounts

Benefit Description	In-Network	Out-of-Network
Individual Calendar Year Deductible (CYD)	$300	$300
Family Calendar Year Deductible (CYD)	$600	$600
Hospital Per Admission Deductible (PAD)	$150 In addition to the CYD and applicable Coinsurance	$150 In addition to the CYD and applicable Coinsurance
Emergency Room Per Visit Deductible	$75 In addition to the CYD and applicable Coinsurance	$75 In addition to the CYD and applicable Coinsurance
Coinsurance Percentage Payable By The Plan Per Calendar Year	75% of Allowed Amount	45% of Allowed Amount
Coinsurance Payable by The Plan for Ambulance Services	75% of the Allowed Amount	75% of the Allowed Amount
Individual Coinsurance Responsibility Limit Per Calendar Year	$7,500	$7,500
Note: Coinsurance Responsibility Limits do not include the CYD amount, the Hospital PAD amount, the Emergency Room Per Visit Deductible amount, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount.		

B. Office Services

Benefit Description	In-Network	Out-of-Network
Office Services Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	75% of Allowed Amount	45% of Allowed Amount
Office Services Rendered by: 1. Physicians other than Family Physicians; and 2. Other health care professionals licensed to perform such services.	75% of Allowed Amount	45% of Allowed Amount
Durable Medical Equipment, Prosthetics and Orthotics	75% of Allowed Amount	45% of Allowed Amount
Note: A Covered Plan Participant should verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's participation status just access any one of our three PPO Networks through our web site at http://monroecofl.virtualtownhall.net/Pages/MonroeCoFl_GroupInsurance/index or contact the Benefits Office at 305-292-4579 or 305-292-4446 for assistance.		

C. Benefit Maximums

Accumulated Total Lifetime Maximum Benefit Per Covered Participant……..……$1,000,000
(includes medical care services & pharmaceuticals)

Adult Wellness Per Covered Plan Participant Every **12** Months Age 40 and over……..…… $400

Adult Wellness Per Covered Plan Participant Every **24** Months Age 39 and under……..…$400

Covered Services as described below for an adult. For purposes of this benefit an adult is 17 years or older.

Adult Wellness Services include:

1. annual physical or gynecological exam; and
2. related wellness services including, but not limited to pap smears; Prostate Specific Antigen (PSA), x-rays, laboratory services, and immunizations. Routine vision and hearing examinations and screenings are <u>not</u> covered.

Note: The wellness services above are not subject to the CYD. Any charges in excess of the maximum allowed by The Plan of $400 are the responsibility of the Covered Plan Participant and do not count toward the Individual Coinsurance Responsibility Limit Per Calendar Year. All wellness claims must have a routine diagnosis to be covered under this benefit.

Autism Spectrum Disorder Per Covered Plan Participant Per Calendar Year/Lifetime…..……$36,000/$200,000

Enteral Formulas Per Covered Plan Participant Per Calendar Year…… ……$2,500

Home Health Care Per Covered Plan Participant Per Calendar Year…… ……..$7,500

Hospice (Combined Inpatient, Outpatient and Home)
Per Covered Plan Participant Per Lifetime…… ……...Unlimited

Outpatient Cardiac, Occupational, Physical, Speech Therapies
Per Covered Plan Participant Per Calendar Year…… ……...…$5,000

Outpatient Private Duty Nursing Visits Per Covered Plan Participant Per Calendar Year……...40

Skilled Nursing Facility Days Per Covered Plan Participant Per Calendar Year…… ....Unlimited

Spinal Manipulations and Massage Therapies Per Covered Plan Participant Per Calendar Year…… …$1,000

TMJ Services Per Covered Plan Participant Per Lifetime…… ……$2,000

D. Admission Certification Requirements

All Hospital admissions must be certified. Any non-certified admissions are subject to a **30%** benefit penalty reduction. The Covered Plan Participant is responsible for obtaining certification for the admission from the Keys Physician-Hospital Alliance (KPHA) and for any applicable benefit reduction for failure to obtain such certification.

E. Prescription Drug Program

Walgreens Health Initiatives, Inc. (WHI) is the Pharmacy Benefits Manager of the pharmacy drug program for the Plan.

Copayments

The copayment is applied to each covered pharmacy drug, mail order or Advantage 90 drug charge and is shown in the Schedule of Benefits. The copayment amount is not a covered charge under the medical plan. Any one pharmacy prescription is limited to a continuous 30-day supply. Any one mail order or Advantage 90 prescription is limited to a continuous 90-day supply. A continuous day supply is defined as the amount of medication a person may be anticipated to require within a contiguous 30 or 90-day period. A medication prescribed "as needed" or not specifying a daily dosage may be dispensed (with physician approval) in a lesser quantity than daily dosing.

Walgreens Health Initiatives (WHI), Monroe County's Pharmacy Benefit Manager (PBM) works with Monroe County to ensure that prescription medications are dispensed in an effective and cost-efficient manner. To this end WHI may:

- Automatically substitute an FDA-approved generic drug for a brand name or formulary drug, unless the prescribing Physician has noted "Dispense As Written" AND "Medically Necessary" on the prescription (the Physician will be contacted to verify). The Plan will require the Covered Plan Participant to pay 100% of the cost of the medication;
- Contact the Physician for permission to substitute a therapeutically equivalent (by FDA guidelines) drug;
- Contact the Physician to re-prescribe if prescribed quantities that do not fall within Plan's day supply guidelines.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Plan Participant's ID card is not used, a Member Prescription Reimbursement Claim Form must be completed and submitted to WHI for reimbursement to the Covered Plan Participant.

<u>Covered Plan Participant Cost</u>

When a Covered Plan Participant's covered prescriptions are filled under this Program, the Covered Plan Participant shares a portion of the cost; the Plan pays for the rest. Covered Plan Participant's costs for the program are as follows:

Retail Pharmacy (short-term medications):

Up to 30-day supply	Generic:	$ 10.00
	Preferred Brand:	$ 25.00
	Non-Preferred Brand:	$ 70.00

Advantage 90
***Retail Pharmacy (long-term medications):**

90-day supply	Generic:	$ 25.00
	Preferred Brand:	$ 62.50
	Non-Preferred Brand:	$175.00

Mail Service (long-term medications):

Up to 90-day supply	Generic:	$ 25.00
	Preferred Brand:	$ 62.50
	Non-Preferred Brand:	$175.00

It is standard pharmacy practice (and in some states, it is even required by law) to substitute generic equivalents for brand-name drugs whenever possible.
When a Covered Plan Participant uses the mail service or participating retail pharmacy, the Covered Plan Participant will receive generic substitutes whenever available and allowable.

Under the Plan's Mandatory Generic Drug Program, whenever a brand-name drug is dispensed when a generic substitute is available and allowable, **the Covered Plan Participant will be responsible for 100% of the cost of the drug.**

NOTE: Should a prescribing Physician write on a prescription "Dispense As Written" and "Medically Necessary" so the brand-name drug will be dispensed, WHI will contact the Physician to verify.

Clinical Prior Authorization Program

Certain prescriptions require "clinical prior authorization," or approval from the Plan, before they will be covered. The categories/medications that require clinical prior authorization may include, but are not limited to: Acne (topical-cover through age 24); Actiq (limit 42 units per 365-day supply); ADHD/Narcolepsy (cover through age 19), Anabolic Steroids (all types), Butorphanol (after two-2.5 ml bottles per 25-day supply), Byetta; Contraceptives; Fentora, Impotency (maximum 8 qty.), Insomnia (limit 30 qty. per 30-day supply); Migraine (after 8 injectable, 8 nasal or 18 oral per 25-day supply), OxyContin (daily average limit of 3) and Symlin.

To confirm whether clinical prior authorization is needed or requested, call 1-877-665-6609. Please have available the name of medication, Physician's name, phone (and fax number, if available), member ID number and group number on the WHI Identification Card.

Step Care

The clinical prior authorization program generally requires utilization of an effective first-line agent before other alternative therapies may be covered. The Plan requires this program to be in place for the following categories: COX-2 Inhibitors; Dipeptidyl Peptidase-4 Inhibitors; Oral Bisphosphomate and Proton Pump Inhibitors (OTC Prilosec). For more information call 1-877-665-6609.

Covered Drugs

- Compound prescription containing at least one legend ingredient
- Federal legend drugs (that is, drugs that federal law prohibits dispensing with a prescription)
- Insulin and other diabetic supplies when prescribed by a Physician.

Drugs Not Covered

- Contraceptives
- Dietary Drugs
- Food and/or food supplements
- Fertility drugs
- Infertility drugs
- Over-the-counter (OTC) items
- Retin-A
- Rogaine (or similar products)

- Smoking deterrents
- Vitamins

This is a *partial* listing of covered and non-covered drugs. Certain prescriptions may require physician confirmation of medical necessity. For specific drug inquiries, contact the WHI Customer Care Center at 1-800-207-2568.

Appeal of Adverse Drug Coverage Determination

Covered Plan Participant's can appeal an adverse drug coverage determination by contacting the Benefits Office at 305-292-4579 to initiate the appeal process.

Participating Pharmacies

There are over 62,000 participating pharmacies to choose from. Below are just some of the local pharmacies who participate in our nationwide retail network.

- Albertsons*
- Dennis Pharmacy*
- Medicine Shoppe
- CVS*
- Publix*
- Walgreens*
- Winn-Dixie*

*pharmacies participating in the 90-day retail program

Note: Participating pharmacies are subject to change without notice

Preferred Medication List – Medication Categories Guide

The Preferred Medication List (PML) was developed by Walgreens Health Initiatives under the direction of a committee of doctors and pharmacists. All medications on this list are preferred by the Plan.

Covered Plan Participant's can make the most of their pharmacy benefit plan and control their prescription medication costs by using this Preferred Medication List. Whenever possible, have your doctor consult this guide for lowest-cost brand-name and generic medications available for your therapy. All medications on the PML have been approved by the FDA.

Please note: The PML is subject to change without notice.

For a Copy or to View the Preferred Medication List – Please visit www.mywhi.com
Questions about the Preferred Medication List – Please call the Walgreens Customer Care Center 1-800-207-2568.

Section 2 - Covered Plan Participant's Financial Obligations

This section sets out a Covered Plan Participant's financial obligations under the Monroe County Group Health Plan Document. Important information concerning these financial obligations is set forth in the Schedule of Benefits.

Calendar Year Deductible Requirement

1. Individual Calendar Year Deductible Requirement: This requirement, when applicable, must be satisfied by each Covered Plan Participant each Calendar Year, before any payment will be made by the Plan. Only those charges indicated on claims received for Covered Services will be credited toward the Individual Calendar Year Deductible requirement and only up to the applicable Allowed Amount.

2. Family Calendar Year Deductible: Once the Covered Employee's family has reached such limit, no Covered Plan Participant in that family will have any additional Calendar Year Deductible responsibility for the remainder of that Calendar Year. The maximum amount that any Covered Plan Participant in the family can contribute toward the Family Calendar Year Deductible requirement is the amount applied toward the Individual Calendar Year Deductible amount.

Note: In situations where the Benefits Office is notified by a Covered Employee that their spouse or Registered Domestic Partner is also a Covered Employee of an Employer and one has elected family coverage only **two** Individual Calendar Year Deductibles are required to satisfy the Family Calendar Year Deductible for both Covered Employees.

Hospital Per Admission Deductible

The Hospital Per Admission Deductible must be satisfied by each Covered Plan Participant, for each Hospital admission, before any payment will be made by The Plan for inpatient Health Care Services. The Hospital Per Admission Deductible applies regardless of the reason for the admission, is in addition to the Calendar Year Deductible requirement, and applies to all Hospital admissions in or outside the state of Florida.

Emergency Room Per Visit Deductible

The Emergency Room Per Visit Deductible is set forth in the Schedule of Benefits. The Emergency Room Per Visit Deductible applies regardless of the reason for the visit, is in addition to the Calendar Year Deductible, and applies to emergency room services in or outside the state of Florida. The Emergency Room Per Visit Deductible must be satisfied by each Covered Plan Participant for each visit. If the Covered Plan Participant is admitted to the Hospital at the time of the emergency room visit, the Emergency Room Per Visit Deductible will be waived.

Coinsurance Responsibility

After the Covered Plan Participant has satisfied the applicable Deductible responsibility, claims for Covered Services will be paid by the Plan at the Coinsurance percentage of the applicable Allowed Amount as set forth in the Schedule of Benefits. The unpaid percentage of the Allowed Amount (for in-network services), or the unpaid percentage of the Allowed Amount plus any additional amount charged by the Provider beyond the Allowed Amount (for out-of-network services), is the Covered Plan Participant's Coinsurance responsibility.

1. Coinsurance Responsibility Limit/Maximum Out-of-Pocket Coinsurance Amount

    a. Individual Coinsurance Responsibility Limit: Once a Covered Plan Participant has reached the Individual Coinsurance responsibility limit amount as set forth in the Schedule of Benefits, the

Covered Plan Participant will have no additional Coinsurance responsibility for the remainder of the Calendar Year and payment for Covered Services will be at 100 percent of the Allowed Amount.

Note: The Individual or Family Calendar Year Deductible, Hospital Per Admission Deductible, Emergency Room Per Visit Deductible, any benefit penalty reduction, non-covered charges and any charges in excess of the Allowed Amount are in addition to the Coinsurance Responsibility Limit.

Additional Financial Responsibilities

In addition to the financial obligations set forth above, Covered Plan Participants are also responsible for:

1. expenses incurred for non-Covered Services;
2. charges in excess of any maximum benefit limitation set forth in the Schedule of Benefits (e.g., the lifetime maximum and Calendar Year maximums);
3. charges in excess of the applicable Allowed Amount on non-emergent use of out-of-network Providers; and
4. any benefit reduction (e.g., benefit penalties resulting from a Covered Plan Participant's failure to comply with any Benefit Utilization Management/Utilization Review Program requirements, non-emergent utilization of out-of-network providers).

Section 3 - Health Care Provider Networks & Reimbursement Rules

Introduction

Covered Plan Participants have access to three Preferred Provider Organization (PPO) Networks under the Plan.

- Keys Physician-Hospital Alliance (305) 294-4599 or (800) 400-0984 (Monroe County)
- Dimension Plus (800) 483-4992 or www.dimensionhealth.com (Miami-Dade, Broward,Palm Beach & Monroe Counties)
- Multiplan/PHCS Network (800) 557-6794 or www.multiplan.com (Nationwide)

Covered Plan Participants are free to obtain services from any health care Provider of their choice, including PPO Providers or health care Providers who do not want to participate in any of our PPO Networks. The reimbursement rules for Covered Services vary, as explained below, depending on the health care Provider selected by a Covered Plan Participant to provide Health Care Services.

To find out about a health care Provider's participation status, a Covered Plan Participant can review the PPO Provider Directories in effect by:

- accessing the Network website (see addresses above);
- accessing the County website at http://monroecofl.virtualtownhall.net/Pages/MonroeCoFl_GroupInsurance/index
- calling the Benefits Office at 305-292-4446 or 305-292-4579; or
- calling the Provider's office directly.

It is the Covered Plan Participant's sole responsibility to select a Provider when obtaining Health Care Services and to verify such Provider's participation status, if any, at the time the Health Care Services are rendered. Please note that certain categories of PPO Providers may not be available in all geographic regions. This includes anesthesiologists, radiologists, pathologists, specialists, and emergency room physicians. The Plan will pay for Covered Services rendered by any Physician listed above at the In-Network benefit level on a case-by-case basis. If Non-Emergency Covered Services were obtained from a Physician who is not a PPO Provider the Out-of-Network benefit level will apply (30% penalty on all related charges). Covered Plan Participants will be responsible for this 30 percent penalty in addition to any Covered Service Charges over the Allowed Amount.

This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit) under the Plan.

When a Covered Plan Participant receives Health Care Services from a PPO Provider, the Plan's payment of expenses for those services which are Covered Services (as defined in the Monroe County Group Health Plan Document) will be at the Coinsurance percentage set forth in the Schedule of Benefits based on the Allowed Amount for such services. The Covered Plan Participant's financial responsibility includes:

1. the payment of any applicable Deductible(s) or Coinsurance requirements;
2. the payment of expenses which are not covered, limited or excluded;
3. the payment of any expenses in excess of any benefit maximum limitations; and
4. the payment of any applicable benefit reductions or penalties.

Section 4 - Pre-existing Conditions Exclusion Period

Introduction

Covered Plan Participants when initially enrolled in the Plan **will be** subject to a Pre-existing Condition exclusionary period, except newborn or adopted dependents who are properly enrolled. A Covered Plan Participant with Creditable Coverage in effect for a continuous period of 12 months or longer prior to initial enrollment **will not** be subject to a Pre-existing Condition exclusionary period.

Definitions

The following definitions will be referred to for the purpose of this Pre-existing Conditions Exclusion Period section:

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Pre-existing Condition means any Condition related to a physical or mental Condition regardless of the cause of the Condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding:

1. the first day of the Covered Plan Participant's Waiting Period for Initial Enrollees; or
2. the Covered Plan Participant's Effective Date of coverage under the Monroe County Group Health Plan Document for special and annual enrollees.

The Pre-existing Condition exclusionary period does not apply to:

1. pregnancy;
2. a newborn child or an adopted newborn child;
3. an adopted child who is covered under Creditable Coverage;
4. Genetic Information in the absence of a diagnosis of the Condition;
5. routine follow-up care of breast cancer after the person was determined to be free of breast cancer.

General

If there is a break in coverage of 63 days or more, no credit will be given for prior Creditable Coverage.

Prior health insurers and/or group health plans are required to provide a certification of Creditable Coverage to the Covered Plan Participant upon termination of his or her coverage.

There is no coverage under the Monroe County Group Health Plan Document to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until the Covered Plan Participant has been continuously covered under the Plan for a 12-month period. This 12-month Pre-existing Condition exclusionary period begins on the first day of the Waiting Period for Initial Enrollees; or the Covered Plan Participant's Effective Date of Coverage under the Plan for Special and Annual Enrollees.

Covered Plan Participants with Creditable Coverage at the Initial Enrollment Period

A Covered Plan Participant who enrolls during the Initial Enrollment Period and has Creditable Coverage will be given credit, beginning the first day of the Waiting Period, for the creditable portion of the Pre-Existing Condition exclusionary period if that Covered Plan Participant has not satisfied a 12-month Pre-Existing Condition exclusionary period. The Covered Plan Participant must furnish certification or relevant corroborating evidence of Creditable Coverage.

Covered Plan Participants without Creditable Coverage at the Initial Enrollment Period

If a Covered Plan Participant enrolls during the Initial Enrollment Period and does not have Creditable Coverage, a Pre-existing Condition will not be covered until the Covered Plan Participant has been covered under the Plan for 12 consecutive months from the Effective Date of Coverage.

Covered Plan Participants with Creditable Coverage at the Annual Open Enrollment or Special Enrollment Periods

A Covered Plan Participant who enrolls during the Annual Open Enrollment Period or Special Enrollment Period and has Creditable Coverage will be given credit, beginning on the Effective Date of Coverage, for the creditable portion of the Pre-existing Condition exclusionary period if that Covered Plan Participant has not satisfied a 12-month Pre-existing Condition exclusionary period. The Covered Plan Participant must furnish certification or relevant corroborating evidence of Creditable Coverage.

Covered Plan Participants without Creditable Coverage at the Annual Open Enrollment or Special Enrollment Periods

If a Covered Plan Participant enrolls during the Annual Open Enrollment Period or Special Enrollment Period and does not have Creditable Coverage, a Pre-existing Condition will not be covered until the Covered Plan Participant has been covered under the Plan for 12 consecutive months from the Effective Date of Coverage.

Section 5 - Benefit Utilization Management /Utilization Review Programs

Introduction

The Keys Physician-Hospital Alliance (KPHA) has agreed to provide certain Utilization Management and Utilization Review Programs for the Plan. In this regard, KPHA has established various Benefit Utilization Management/Utilization Review Programs ("UM/UR Programs"), including Admission Certification, Outpatient Diagnostic Procedures & Services Certification, Concurrent Review, Discharge Planning and Catastrophic Claims Case Management. These programs help facilitate the management and review of coverage and benefits provided under the Monroe County Group Health Plan Document and, under certain limited circumstances, present opportunities for alternative benefits or payment alternatives for cost-effective Health Care Services. The UM/UR Programs and requirements described in this Section will apply as of the date this restatement of the Monroe County Group Health Plan Document is approved by the Board of County Commissioners.

Important Information Relating to Keys Physician-Hospital Alliance's UM/UR Programs

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely the responsibility of the Covered Plan Participant together with the Covered Plan Participant's treating Physicians and health care Providers. Covered Plan Participants and their Physicians are responsible for deciding what medical care should be rendered or received and when and how that care should be provided. The KPHA is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under the Monroe County Group Health Plan Document. In fulfilling this responsibility, neither KPHA nor the Plan shall be deemed to participate in or override the medical decisions of any Covered Plan Participant's health care Provider.

Admission Certification Program

The Admission Certification Program helps KPHA determine, for coverage and payment purposes only, whether an admission is Medically Necessary as defined herein. In administering the Admission Certification Program, KPHA may review specific medical facts or information and assess, among other things, the appropriateness, health care setting and/or the level of care of a Hospital admission. Any reviews or assessments of specific medical facts or information by KPHA are solely for the purpose of making coverage or payment decisions under the Plan and not for the purpose of recommending or providing medical care.

Admission Certification Requirements for Inpatient Admissions To Hospitals

The Admission Certification Program requires Covered Plan Participants to obtain from KPHA certification for ANY admission (e.g., elective, planned, urgent or emergency) to a Hospital. If the Covered Plan Participant fails to obtain certification from KPHA for the admission, the Allowance for such admission will be reduced by 30 percent as a penalty. This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

Obtaining Pre-admission Certification from Keys Physician-Hospital Alliance (KPHA)

1. Planned Admissions – For all planned admissions (i.e., and inpatient Hospital admission which is not an emergency or urgent) to a Hospital the Covered Plan Participant must contact KPHA at 305-294-4599 or 800-400-0984 at least three to five days prior to the planned admission for Preadmission Certification & Length of Stay Approval. This means that KPHA must certify the hospital admission and approve the number of days for which certification is given, before the services are provided. **If the Hospital admission is denied, but the Covered Plan Participant is admitted to the Hospital anyway, benefits for Covered Services will be reduced by 30% of covered charges.** If confinement extends beyond the approved Length of Stay, additional days must be pre-certified by KPHA. Full benefits for hospital charges will be paid only for the approved number of extended confinement days. **All covered charges incurred during that hospitalization will be reduced by 30 percent for those extended confinement days not approved.**

2. Unplanned Admissions – For all unplanned admissions (i.e., an inpatient Hospital admission that is an emergency or is urgent or cannot be scheduled in advance) to a Hospital the Covered Plan Participant must ensure that the Physician or the Hospital contacts KPHA by telephone within 24 hours of the admission or the first business day following a weekend or holiday admission. In the event the Covered Plan Participant's Condition makes it impossible for the Covered Plan Participant to ensure that KPHA is so notified within the applicable time frame, the Covered Plan Participant must ensure that KPHA is so notified as soon as possible.

3. KPHA's Certification Decision – Once KPHA has received and reviewed the necessary information, KPHA will make a certification decision, for coverage and payment purposes only, based upon the Admission Certification program's criteria then in effect. KPHA will notify the Covered Plan Participant, the Physician and the Hospital of the certification decision as soon as possible.

Outpatient Diagnostic Procedures & Services Certification

For scheduled, non-emergency Outpatient Diagnostic Procedures (e.g., MRI, CT Scan) and Services (e.g., Durable Medical Equipment, Home Health Services) the Covered Plan Participant must contact KPHA at 305-294-4599 or 800-400-0984 at least three to five days prior to the scheduled procedure. KPHA will review for determination of medical necessity.

Below is a list of outpatient diagnostic procedures and services that require Certification from KPHA **prior** to the scheduled Diagnostic Procedure and/or Services.

- Certification must be obtained on ALL MRI, MRA, CTA, CT Scans and PET Scans;
- Certification must be obtained on ALL Outpatient physical, occupational & speech therapy referrals;
- Certification must be obtained on ALL 30-day Outpatient Cardiac Therapy;
- Certification must be obtained on ALL sleep studies and follow-up titration studies in conjunction with CPAP referrals;
- Certification must be obtained on ALL TMJ care and prescribed Orthotic Devices;
- Certification must be obtained on ALL Durable Medical Equipment (i.e., wheelchairs, hospital beds, CPAP machines, oxygen); and
- Certification must be obtained on ALL Home Health Service

In the event the Covered Plan Participant fails to obtain prior certification from KPHA on any Procedure and/or Service listed above the Allowed Amount will be reduced by 30 percent as a penalty. This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

Concurrent Review Program

Under this UM/UR program, KPHA will review Hospital stays and other health care treatment programs during the course of such stay or treatment program. Any such review is conducted solely to determine whether coverage and/or payment should continue for a particular admission. Using established criteria then in effect, concurrent review of the Hospital stay will occur at regular intervals. KPHA will provide the Covered Plan Participant's Physician with notification when KPHA's criteria under this program for coverage and payment for continued inpatient care are no longer met. In administering the Concurrent Review Program, KPHA may review specific medical facts or information and assess, among other things, the appropriateness, health care setting and/or the level of care of a Hospital admission. Any reviews or assessments of specific medical facts or information by KPHA are solely for the purpose of making coverage or payment decisions under the Plan and not for the purpose of recommending or providing medical care.

Discharge Planning

Under this UM/UR program KPHA will help the Covered Plan Participant and the Covered Plan Participant's Physician identify health care resources that may be available in the Covered Plan Participant's community following hospitalization. KPHA will, upon request, answer questions the Covered Plan Participant's Physician has regarding the Covered Plan Participant's coverage or benefits under the Monroe County Group Health Plan Document following discharge from the Hospital.

Case Management Program

Under this UM/UR program KPHA provides Case Management services for those Covered Plan Participants who have a catastrophic or chronic condition. KPHA case managers act as liaison between the Covered Plan Participant, Physician, Therapist, Third Party Administrator and Employer coordinating all services so that each Covered Plan Participant can return to their optimal potential. Examples of catastrophic illnesses or injuries include, but are not limited to:

- Major Head Trauma and Brain Injury Secondary to Illness
- Amyotrophic Lateral Sclerosis (ALS)
- Multiple Sclerosis (MS)
- Neonatal High Risk Infant
- Spinal Cord Injuries
- Multiple Fractures
- Severe Burns
- Amputations
- Transplants
- Leukemia
- Cancer
- AIDS
- Home Health Needs
- Durable Medical Equipment Needs
- Any Claim expected to exceed $30,000

When KPHA is notified of one of the above diagnoses or needs (or any other diagnosis for which KPHA feels Case Management is appropriate) by the Covered Plan Participant, Physician, or Wells Fargo TPA, the KPHA Case Manager will develop a plan of treatment which will include all services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified as the Covered Plan Participant's condition or needs change.
Under this program the Plan and KPHA may elect to (but is not required to) offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available on a case-by-case basis to Covered Plan Participants who meet KPHA criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which the Covered Plan Participant and the Covered Plan Participant's Physician agree.

Offering to provide, or actually, providing any alternative benefits or payments in no way obligates the Plan or KPHA to continue to provide such alternative benefit payments, or to provide alternative benefits or payments to the Covered Plan Participant or any other person insured by the Plan at any time. Nothing contained in this section shall be deemed a waiver of the Plan's right to enforce the Monroe County Group Health Plan Document in strict accordance with its terms.

Appeal Process

The Covered Plan Participant, a treating Physician or a Hospital may request that KPHA review a UM/UR Program coverage or payment decision, provided such request is received by KPHA in writing within 90 days of the date of the decision. The review request must include all information deemed relevant or necessary by KPHA. KPHA will review the decision in light of such information and notify the Monroe County Group Health Plan Administrator of the review decision. Upon approval from the Monroe County Group Health Plan Administrator the KPHA will notify the Covered Plan Participant, the Hospital and/or the Physician of the final decision.

Section 6 - Medical Necessity

In order for Health Care Services to be covered under the Monroe County Group Health Plan, such services must be: 1) not otherwise limited or excluded under the Monroe County Group Health Plan Document; 2) rendered while coverage is in force; 3) within the service categories set forth in the Covered Services section; and 4) Medically Necessary, as defined in the Definitions section of the Monroe County Group Health Plan Document.

It is important to remember that any review of Medical Necessity by Wells Fargo TPA, KPHA or the Monroe County Group Health Plan Administrator is solely for the purposes of determining coverage or benefits under the Monroe County Group Health Plan Document and not for the purpose of recommending or providing medical care. In this respect, Wells Fargo TPA, KPHA or Monroe County Group Health Plan Administrator may review specific medical facts or information pertaining to a Covered Plan Participant. Any such review, however, is strictly for the purpose of determining, among other things, whether a Health Care Service provided or proposed meets the applicable coverage and payment guidelines then in effect.

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are the sole responsibility of the Covered Plan Participant and the Covered Plan Participant's treating Physicians and health care Providers. Covered Plan Participants and their Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. In making coverage decisions, neither Wells Fargo TPA nor KPHA nor the Monroe County Group Health Plan Administrator shall be deemed to participate in or override the medical decisions of a Covered Plan Participant or a Covered Plan Participant's health care Providers.

Examples of hospitalization and other Health Care Services that are not Medically Necessary include, but are not limited to:

1. continued hospitalization because arrangements for discharge have not been completed;
2. use of laboratory, x-ray, or other diagnostic testing that has no clear indication, or is not expected to alter the treatment plan;
3. hospitalization because supervision in the home, or care in the home, is inconvenient; or hospitalization for any service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department); or
4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members.

Medical Decisions - Responsibility of Covered Plan Participant

Any and all decisions that require or pertain to independent professional medical judgement or training, or the need for medical services or supplies, must be made solely by the Covered Plan Participant, the Covered Plan Participant's family and the Covered Plan Participant's treating Physician in accordance with the patient/physician relationship. It is possible that the Covered Plan Participant or the Covered Plan Participant's treating Physician may conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Note: Whether or not a Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the service is Medically Necessary (as defined by the Monroe County Group Health Plan Document) or a Covered Service. Please refer to the Definitions section of the Monroe County Group Health Plan Document for the definitions of "Medically Necessary" or "Medical Necessity."

Section 7 - Covered Services

Introduction

The following subsections describe the Health Care Services which may be Covered Services under the Monroe County Group Health Plan Document. All benefits for Covered Services are subject to the Covered Plan Participant's applicable financial responsibilities, benefit maximums (e.g., Calendar Year Deductible and Lifetime Maximum), the applicable Allowed Amount, limitations, exclusions, and all other provisions contained in the Monroe County Group Health Plan Document (including the Schedule of Benefits) in accordance with Wells Fargo TPA's Medical Necessity criteria and guidelines then in effect.

Expenses for the Health Care Services listed below will be covered under the Plan only if the services are:

1. within the services' categories set forth in this Covered Services section;
2. rendered by appropriate licensed health care Provider who is recognized for payment herein;
3. Medically Necessary as defined in the Monroe County Group Health Plan Document;
4. rendered while a Covered Plan Participant's coverage is in force; and
5. not specifically or generally limited (e.g., Pre-existing Condition exclusionary period) or excluded under the Monroe County Group Health Plan Document.

Note: More than one limitation or exclusion may apply to a specific Health Care Service or a particular situation.

Under most circumstances, Wells Fargo TPA will determine whether Health Care Services are Covered Services under the Plan when processing a Covered Plan Participant's claim after the Covered Plan Participant has obtained such services and a claim has been received by Wells Fargo TPA for such services. In some circumstances, Wells Fargo TPA or the Monroe County Group Health Plan Administrator may, but are not required to, determine whether Health Care Services are Covered Services under the Monroe County Group Health Plan Document before the Covered Plan Participant is provided the service. For example, Wells Fargo TPA or the Monroe County Group Health Plan Administrator may determine whether a proposed transplant is a Covered Service under the Monroe County Group Health Plan Document before such transplant is provided.

Benefit Guidelines

In providing benefits for Covered Services, the benefit guidelines set forth below apply as well as any other applicable reimbursement rules specific to particular categories of Heath Care Services:

1. The reimbursement for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable for any such services and/or supplies.

2. The reimbursement is based on the Allowed Amount for the actual service rendered (i.e., not based on the Allowed Amount for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the week nor the time of day the procedure is performed.

3. The reimbursement for a service includes all components of the service when such service can be described by a single procedure code, or when the service is an essential or integral part of the associated therapeutic/diagnostic service.

Covered Services Categories

The Health Care Services listed below may be Covered Services under the Monroe County Group Health Plan Document. For ease of reference, limitations and exclusions which apply to specific services have been included in this section. Any specific limitations and/or exclusions included in this section are in addition to any other limitations and/or exclusions listed in the Monroe County Group Health Plan Document including those listed in the General Exclusions section.

- **Accident Care**

Health Care Services to treat an injury or illness resulting from an Accident **not** arising as a result of the Covered Plan Participant's job or employment.

- **Adult Wellness Services**

Refer to the Schedule of Benefits for Covered Services and benefit maximums.

Exclusion: Any charges over the maximum allowable of $400 by the Plan are the responsibility of the Covered Plan Participant and do not count toward the Individual Coinsurance Responsibility Limit Per Calendar Year.

- **Allergy Testing and Treatments**

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization serum. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

- **Ambulance Services**

Ambulance services (ground or air) to transport a Covered Plan Participant from:

1. a Hospital unable to provide proper care to the nearest Hospital that can provide proper care;
2. a Hospital to the Covered Plan Participant's nearest home or Skilled Nursing Facility; or
3. the place a medical emergency occurs to the nearest Hospital that can provide proper care.

- **Ambulatory Surgical Centers**

Health Care Services rendered at an Ambulatory Surgical Center including:

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. drugs and medicines administered (except for take home drugs) at the Ambulatory Surgical Center;
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration of, including the cost of, whole blood or blood products;
8. transfusion supplies and equipment;
9. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

- **Anesthesia Administration Services**

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA"). In those instances where the CRNA is actively directed by a Physician other than the Physician who performed the surgical procedure, payment for Covered Services, if any, will be made for both the CRNA and the Physician services at the lower directed-services Allowed Amount in accordance with the payment program for such services then in effect.

Exclusion – Coverage does not include anesthesia services by an operating Physician, his or her partner or associate.

- **Autism**

The following services are covered as they relate to "Autism Spectrum Disorder" defined as autism disorder, Asperger's Syndrome, and other pervasive developmental disorders not otherwise specified. Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder, and Treatment of autism spectrum disorder through: Therapy, including Speech, Occupational and/or Physical Therapy; and Applied Behavior Analysis, which is the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.

To be eligible for services, the Covered Plan Participant must be under 18 years of age; or 18 years of age or older in high school and diagnosed as having a developmental disability at 8 years of age or younger.

Exclusion – The Plan will not pay for Covered Services which exceed the annual or lifetime maximums for Autism Spectrum Disorder listed in the Schedule of Benefits.

- **Breast Reconstructive Surgery**

Breast Reconstructive Surgery and implanted prostheses incident to Mastectomy. In order to be covered, such surgery must be provided in a manner chosen by the Covered Plan Participant's Physician, consistent with prevailing medical standards, and in consultation with the Covered Plan Participant.

- **Child Cleft Lip and Cleft Palate Treatment**

Treatment and services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition services for treatment of a child under the age of 18 who has cleft lip or cleft palate. In order for such services to be covered, the Covered Plan Participant's Physician must specifically prescribe such services and such services must be consequent to treatment of the cleft lip or cleft palate.

- **Concurrent Physician Care**

Physician medical services, provided: (a) the additional Physician actively participates in the Covered Plan Participant's treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the specialty with different sub-specialties.

- **Consultations**

Consultations provided by a Physician are covered if the attending Physician requests the consultation and the consulting Physician prepares a written report.

- **Dental**

Dental Care is limited to the following:

1. Care and treatment initiated within 90 days of an Accidental Dental Injury provided such services are for the treatment of damage to sound natural teeth.

2. Extraction of teeth required prior to radiation therapy when the Covered Plan Participant has a diagnosis of cancer of the head and/or neck.

3. Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Covered Plan Participant in a Hospital or Ambulatory Surgical Center if:

    a. the Covered Plan Participant is under 8 years of age and it is determined by a dentist and the Covered Plan Participant's Physician that: 1) dental treatment is necessary due to a dental Condition that is significantly complex; or 2) the Covered Plan Participant has a developmental disability in which patient management in the dental office has proven to be ineffective; or

    b. the Covered Plan Participant has one or more medical Conditions that would create significant or undue medical risk for the Covered Plan Participant in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

4. Oral Surgery limited to the following procedures:

    a. Health Care Services provided for the excision of impacted teeth at any location (i.e., inpatient hospital, surgery, associated x-rays and anesthesia); and
    b. Apicoectomy (excision of tooth root without extraction of the tooth); and
    c. Cutting procedures on the gums and mouth tissues for treatment of disease; and/or
    d. Osseous surgery to modify and reshape deformities in the supporting bone around the teeth and is used when periodontal disease is advanced in nature.

Exclusion – Dental Services provided more than 90 days after the date of an Accidental Dental Injury regardless of whether or not such services could have been rendered within 90 days; and Dental Implants.

- **Diabetes Outpatient Self-Management**

Diabetes outpatient self-management training and educational services and nutrition counseling (including all medically appropriate and necessary equipment and supplies) to treat diabetes, if the Covered Plan Participant's treating Physician or a Physician who specializes in the treatment of diabetes certifies that such services are necessary. In order to be covered, diabetes outpatient self-management training and educational services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed Dietitian.

Covered Services may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

- **Diagnostic Services**

Diagnostic services when ordered by a Physician are limited to the following:

- radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);
- laboratory and pathology services;
- services involving bones or joints of the jaw (e.g., services to treat temporomandibular joint (TMJ) dysfunction) or facial region if, under accepted medical standards, such diagnostic services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
- approved machine testing (e.g., electrocardiogram (EKG), and other electronic diagnostic medical procedures); and
- genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

- **Dialysis Services**

Including equipment, training, and medical supplies, when provided at any location, by a Dialysis Center or a Provider licensed to perform dialysis.

- **Durable Medical Equipment**

Durable Medical Equipment (DME) when provided by a Durable Medical Equipment Provider and when prescribed for a Covered Plan Participant by a Physician, limited to the most cost effective Durable Medical Equipment, which meets the Covered Plan Participant's needs as determined by KPHA.
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Reimbursement Guidelines for Durable Medical Equipment (DME)

Supplies and service to repair medical equipment may be Covered Services only if the Covered Plan Participant owns the equipment or is purchasing the equipment. The Allowed Amount for DME will be the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) the Allowed Amount. The total Allowed Amount for such rental equipment will not exceed the total purchase price. DME includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Note: Repair or replacement of Durable Medical Equipment due to growth of a child or due to a change in the Covered Plan Participant's Condition is a Covered Service.

Exclusion – Equipment which is primarily for the convenience and/or comfort of the Covered Plan Participant, the Covered Plan Participant's family or caretakers; modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; electric scooters; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment; hearing aids; air conditioners and purifiers; humidifiers; water softeners and/or purifiers; pillows, mattresses or waterbeds; escalators, elevators, stair glides; emergency alert equipment; handrails and grab bars; heat appliances and dehumidifiers; and the replacement of Durable Medical Equipment solely because it is old or used are excluded.

In the event the Covered Plan Participant fails to obtain prior certification from KPHA on any Durable Medical Equipment the Allowed Amount will be reduced by 30 percent as a penalty. This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

- **Enteral Formulas**

Prescription and non-prescription enteral formulas for home use when prescribed by a Physician as necessary to treat inherited diseases of amino acid, organic acid, carbohydrate or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period.

Coverage to treat inherited diseases of amino acid or organic acids, for any Covered Plan Participant up to their 25th birthday, shall include coverage for food products modified to be low protein.

Benefits for low protein food products are limited as set forth in the Schedule of Benefits.

- **Eye Care**

Coverage includes the following services:

1. Physician services, soft lenses or sclera shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician services to treat an injury or disease to a Covered Plan Participant's eyes.

Exclusion – Health Care Services to diagnose or treat vision problems which are not a direct consequence of trauma or prior ophthalmic surgery; eye examinations; eye exercises or visual training; eye glasses and contact lenses and their fitting are excluded. In addition to the above, any surgical procedure performed primarily to correct or improve myopia or other refractive disorders (e.g., radial keratotomy, PRK and LASIK) are excluded.

- **Home Health Care**

The following Home Health Care Services only when: 1) the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; 2) the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan that has been reviewed and renewed by the Covered Plan Participant's Physician every 30 days; 3) the Covered Plan Participant is meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes; and 4) the Covered Plan Participant is confined to home and is unable to carry out the basic activities of daily living.

Home Health Care Services are limited to:

1. part-time (i.e., less than 8 hours per day and less than a total of 40 hours in a calendar week) or intermittent (i.e., a visit of up to, but not exceeding, 2 hours per day) nursing care by a Registered Nurse or Licensed Practical Nurse and/or home health aide Services;
2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and rendered under the supervision of a Registered Nurse;
3. medical social services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen); and

6. Physical Therapy by a Physical Therapist, Occupational Therapy by a Occupational Therapist, and Speech Therapy by a Speech Therapist.

Benefits for Covered Services for Home Health Care are limited as set forth in the Schedule of Benefits. In the event the Covered Plan Participant fails to obtain prior certification from KPHA on any Home Health Care the Allowed Amount will be reduced by 30 percent as a penalty. This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

Exclusion -

1. any Home Health Care service which is not directly provided by (or indirectly provided) through a Home Health Agency;
2. homemaker services; domestic maid services;
3. sitter services; companion services;
4. services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center; or a nursing home facility;
5. Custodial Care except for any such care covered under this subsection when provided on a part-time or intermittent basis (as defined above) by a home health aide;
6. food, housing, and home delivered meals.

- **Hospice Services**

Health Care Services provided to a Covered Plan Participant in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by the Covered Plan Participant's Physician and the Covered Plan Participant is not expected to live more than one year. Wells Fargo TPA shall have the right to request that a Covered Plan Participant's Physician certify in writing the life expectancy of a Covered Plan Participant.

- **Hospital Services**

Covered Hospital Services including:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery room;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic services, including radiology, ultrasound, laboratory, pathology, and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, Cardiac Therapies; and
14. transplants as set forth in the Transplant subsection.

Exclusion – Expense for the following Hospital Health Care Services are excluded when such services could have been provided without admitting the Covered Plan Participant to the Hospital: 1) room and board provided during the Covered Plan Participant's admission; 2) Physician visits provided while the Covered Plan Participant was an inpatient; and 3) Occupational Therapy, Speech Therapy, Physical Therapy, Cardiac Therapy; and 4) other Services provided while the Covered Plan Participant was inpatient.

In addition, expenses for the following are also excluded:

1. gowns and slippers;
2. shampoo, toothpaste, body lotions and hygiene packets;
3. take-home drugs;
4. telephone and television;
5. guest meals or gourmet menus; and
6. admission kits.

- **Inpatient Rehabilitation**

Inpatient Rehabilitation Services are covered when the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is limited to the specific acute, catastrophic target diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders, and/or severe burns;
4. the Covered Plan Participant must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration as to make it impractical for the individual to receive services in a less intensive setting.

Exclusion: Pain Management and respiratory ventilator management Services are excluded.

- **Massage Therapy**

Massage provided by a Physician, Massage Therapist, or Physical Therapist when the massage therapy is prescribed as being Medically Necessary by a Physician licensed pursuant to *Florida Statutes* Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Covered Plan Participant's Physician's prescription must specify the number of treatments.

Exclusion – Application or use of the following or similar technique or items for the purpose of aiding in the provisions of a Massage: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light, Hubbard tank, contrast baths are excluded.

Benefits for Covered Services for Massage Therapy are limited as set forth in the Schedule of Benefits.

- **Mammograms**

Mammograms obtained in a medical office, medical treatment facility or through a health testing service that uses radiological equipment registered with the appropriate Florida regulatory agencies (or those of another state) for diagnostic purposes or breast cancer screening, are Covered Services.
Routine mammograms are limited to the following per *Florida Statute*:

- A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age;
- A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the Covered Plan Participant's Physician's recommendation;
- A mammogram every year for any woman who is 50 years of age or older;
- One or more mammograms a year, based upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.

The Plan covers 100% of the cost of routine mammograms as outlined above. Per Section 627.6613, Florida Statutes, there is no additional charge to the Covered Plan Participant for routine mammograms when rendered by a PPO Network Provider, including but not limited to the Calendar Year Deductible and Coinsurance.

- **Mastectomy Services**

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by the Covered Plan Participant's attending Physician and the Covered Plan Participant. Outpatient post-surgical follow-up care for Mastectomy services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Covered Plan Participant. The treating Physician, after consultation with the Covered Plan Participant, may choose the appropriate setting.

- **Maternity Services**

Health Care Services, including prenatal care, delivery and postpartum care and assessment, provided to a Covered Plan Participant, by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Hospital, Birth Center, Midwife or Certified Nurse Midwife may be Covered Services. Care for the mother includes the postpartum assessment.

In order for the postpartum assessment to be covered, such assessment must be provided at a Hospital, an attending Physician's office, an outpatient maternity center, or in the home by a qualified licensed health care professional trained in care for a mother. Coverage under the Plan for the postpartum assessment includes coverage for the physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards.

- **Mental Health Services**

Diagnostic evaluation, psychiatric treatment, individual therapy, and group therapy provided to a Covered Plan Participant by a Physician, Psychologist, or Mental Health Professional for the treatment of a Mental Health Professional for the treatment of a Mental and Nervous Disorder may be covered. These Health Care Services include inpatient, outpatient, and Partial Hospitalization services.

Partial Hospitalization is a Covered Service when provided under the direction of a Physician and in lieu of inpatient hospitalization and is combined with the inpatient Hospital benefit.

Exclusion

1. Services rendered in connection with a Condition not classified in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;
3. Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. Services for marriage counseling, when not rendered in connection with a Condition not classified in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders;
5. Services for pre-marital counseling;
6. Services for court ordered care or testing, or required as a condition of parole or probation;
7. Services for testing aptitude, ability, intelligence or interest;
8. Services for testing and evaluation for the purpose of maintaining employment;
9. Services for cognitive remediation;
10. inpatient confinements that are primarily intended as a change of environment; or
11. inpatient (over night) mental health services received in a residential treatment facility.

- **Newborn Care**

A newborn child of a Covered Plan Participant shall be covered from the moment of birth provided that the newborn child is eligible for coverage and properly enrolled. Covered Services shall consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth.

Newborn Assessment

An assessment of the newborn child provided the services were rendered at a Hospital, at the attending Physician's office, at a Birth Center, or in the home by a Physician, Midwife or Certified Nurse Midwife, and the performance of any necessary clinical tests and immunizations in keeping with prevailing medical standards.

Expenses for these services are not subject to the Calendar Year Deductible, but are subject to the Coinsurance.

Ambulance services, when necessary to transport the newborn child to and from the nearest appropriate facility which is staffed and equipped to treat the newborn child's Condition, as determined by Wells Fargo TPA and certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn child.

- **Orthotic Devices**

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets when prescribed by a Physician.

Benefits may be provided for necessary replacement of an Orthotic Device which is owned by the Covered Plan Participant when due to irreparable damage, wear, a change in Covered Plan Participant's Condition, or when necessitated due to growth of a child.
Reimbursements for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six-month period unless determined by KPHA to be Medically Necessary.

Exclusion

1. Expenses for arch supports, shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless of intended use, except for therapeutic shoes (including insert and/or modifications) for the treatment of severe diabetic foot disease;
2. Expenses for orthotic appliances or devices which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets), except when the orthotic appliance or device is used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
3. Expenses for devices necessary to exercise, train, or participate in sports, (e.g., custom-made knee braces).

Benefits for Covered Services for TMJ Services are limited as set forth in the Schedule of Benefits. In the event the Covered Plan Participant fails to obtain prior certification from KPHA on any Orthotic Device the Allowed Amount will be reduced by 30 percent as a penalty. This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

- **Osteoporosis Screening, Diagnosis, and Treatment**

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;
3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

- **Outpatient Cardiac, Occupational, Physical, Speech, and Spinal Manipulation**

1. Outpatient therapies listed below when ordered by a Physician or other health care professional licensed to perform such services:

    - **Cardiac Therapy:** Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occulusion or coronary bypass surgery.

    - **Occupational Therapy:** Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition.
    - **Physical Therapy:** Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition.

- **Speech Therapy:** Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition.

Benefits for Covered Services for Outpatient Cardiac, Occupational, Physical, Speech Therapies are limited as set forth in the Schedule of Benefits. In the event the Covered Plan Participant fails to obtain prior certification from KPHA on any Cardiac, Occupational, Physical or Speech Therapies the Allowed Amount will be reduced by 30 percent as a penalty. This penalty is the Covered Plan Participant's responsibility and is in addition to all applicable obligations and limitations under the Monroe County Group Health Plan Document (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

Exclusion – Application or use of the following or similar techniques or items for the purpose of aiding in the provision of a Massage: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank, contrast baths are excluded.

- **Spinal Manipulations:** Services by Physicians for manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray.

Benefits for Covered Services for Spinal Manipulations are limited as set forth in the Schedule of Benefits.

- **Oxygen**

Expenses for oxygen, the equipment necessary to administer it, and the administration of oxygen are covered.

- **Physician Services**

Medical or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office, in an outpatient facility.

- **Preventive Child Health Supervision Services**

Periodic Physician-delivered or Physician-supervised services from the moment of birth up to the 17th birthday as follows:

1. periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
2. oral and/or injectable immunizations; and
3. laboratory tests normally performed for a well child.

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, or the Advisory Committee on Immunization Practices established under the Public Health Service Act.

Expenses for these services are not subject to the Calendar Year Deductible, but are subject to the Coinsurance.

- **Prosthetic Devices**

The following Prosthetic Devices are covered when prescribed by a Physician:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery;
2. appliances needed to effectively use artificial limbs or corrective braces;
3. penile prosthesis and surgery to insert penile prosthesis when necessary in the treatment of organic impotence resulting from: treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, epispadias, and exstrophy.

Benefits may be provided for necessary replacement of a Prosthetic Device which is owned by the Covered Plan Participant when due to irreparable damage, wear, or a change in the Covered Plan Participant's Condition, or when necessitated due to growth of a child.

Covered Prosthetic Devices (except cardiac pacemakers and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is determined to be Medically Necessary) prescribed for each specific Condition.

Exclusion:

1. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g., C-legs); and
2. Expenses for cosmetic enhancements to artificial limbs.

- **Skilled Nursing Facilities**

The following Health Care Services may be Covered Services when: 1) the Covered Plan Participant is an inpatient in a Skilled Nursing Facility; and 2) the Covered Plan Participant's Physician submits a treatment plan that is acceptable to Wells Fargo Third Party Administrator and/or the Monroe County Group Health Plan Administrator for coverage and payment purposes:

1. room and board;
2. respiratory, pulmonary, or inhalation therapy (e.g., oxygen)
3. drugs and medicines administered while an inpatient (except take-home drugs);
4. intravenous solutions;
5. administration of, including the cost of, whole blood and blood products;
6. dressings, including ordinary casts;
7. transfusion supplies and equipment;
8. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
9. chemotherapy treatment for proven malignant disease; and
10. Physical, Speech, and Occupational Therapy.

Exclusion – Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members or the Provider.

- **Substance Dependency Care and Treatment**

Care and treatment of Substance Dependency including:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided to a Covered Plan Participant by a Physician or Psychologist in a program accredited by the Joint Commission of the Accreditation of Healthcare Organizations or approved by the state of Florida for Detoxification or Substance Dependency; and

2. Physician and Psychologist outpatient visits for the care and treatment of Substance Dependency.

- **Surgical Assistant Services**

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary. The Allowed Amount for such is limited to 20 percent of the surgical procedure's Allowed Amount.

- **Surgical Procedures**

Surgical procedures performed by a Physician including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;

2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;

3. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;

4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint (TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;

5. surgical procedures performed on a Covered Plan Participant for the treatment of Morbid Obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and the associated care provided the Covered Plan Participant meets **all** of the following criteria:

    - the Covered Plan Participant has not previously undergone the same or similar procedure in the lifetime of the Plan;
    - before proceeding with a gastric procedure, the Covered Plan Participant shall be actively engaged in a disease management program for obesity for a minimum of six (6) months. This program must be supervised by a Physician and include nutrition and exercise, including dietitian consultation, low calorie diet, increase physical activity and behavioral modification. This program must be documented in a medical record that includes: 1) regular monthly Physician visits; 2) participation in nutrition and exercise programs that are supervised by a Physician working in cooperation with dietitians and/or nutritionists; and 3) healthy activity with supervised exercise three (3) to five (5) times a week;
    - the Covered Plan Participant must enter a dedicated bariatric program with dietary/nutrition and psychological/psychiatric preoperative evaluation and the program must address long-term lifestyle management;

- the need for surgery must be documented by a Physician other than the surgeon for the bariatric procedure;
- Morbid Obesity must have existed for five (5) years prior to surgical consideration and documented by Physician records;
- weight loss dietary and exercise program must occur for a minimum of six (6) months or longer prior to surgery, must be within the two (2) years prior to surgery and must be documented in a medical record, not a summary letter from the Physician.

If the Covered Plan Participant fails to achieve a 10% reduction in BMI, he/she may be eligible for surgery if BMI>35 with co-morbidities or BMI>40.

Exclusion – Surgical procedures for the treatment of Morbid Obesity including: intestinal bypass, stomach stapling, balloon dilation and associate care for the surgical treatment of Morbid Obesity, if the Covered Plan Participant has previously undergone the same or similar procedures in the lifetime of the Plan. Surgical procedures performed to revise, or correct defects related to the surgical procedures, including but not limited to a prior intestinal bypass, stomach stapling or balloon dilation are also excluded.

6. services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.

Reimbursement Guidelines for Surgical Procedures

- Reimbursement for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance indicated in the Covered Plan Participant's Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service;

- Reimbursement for Incidental Surgical Procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "Incidental Surgical Procedure" is defined as a surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in the opinion of Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator, is not clearly identified and/or do not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in the conjunction with a Medically Necessary hysterectomy is an Incidental Surgical Procedure (i.e., there is no reimbursement for the removal of the normal appendix in the example); and

- Reimbursement for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

- **Transplant Services**

Limited to the procedures listed below, if coverage has been predetermined by Wells Fargo Third Party Administrator and the Monroe County Group Health Plan Administrator, subject to the conditions and limitations described below.
Transplant includes pre-transplant, transplant and post-discharge services, and treatment of complications after transplantation. Benefits will only be paid for services, care and treatment received or in connection with a:

1. Bone Marrow Transplant which is specifically listed in the rule 59B-12.001 of the *Florida Administative Code* or any successor or similar rule or covered by Medicare as described in the most recent published Medicare Coverage Issues Manual issued by the Center for Medicare and Medicaid Services. Coverage will be provided for the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for a Covered Plan Participant and will be subject to the same limitations and exclusions as would be applicable to a Covered Plan Participant. Covered expenses include the reasonable expenses of searching among immediate family members and donors identified through the National Bone Marrow Donor Program;

2. corneal transplant;

3. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);

4. heart-lung combination transplant;

5. liver transplant;

6. kidney transplant;

7. pancreas transplant;

8. pancreas transplant performed simultaneously with a kidney transplant, or

9. lung-whole single or whole bilateral transplant.

In order to ensure that a proposed transplant is covered, the Covered Plan Participant or the Covered Plan Participant's Physician should notify Wells Fargo TPA in advance of the Covered Plan Participant's initial evaluation for the procedure. Corneal and kidney transplants do not require prior benefit determination.

Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator will make a prior benefit determination concerning the proposed transplant, however, Wells Fargo TPA must be given the opportunity to evaluate the clinical results of the Covered Plan Participant's initial evaluation for the transplant as well as any applicable protocols. If Wells Fargo TPA is not given an opportunity to make the prior benefit determination, the transplant may be subject to a reduction in payment in accordance with the rules set forth in the Benefits Utilization Management/Utilization Review Programs Section. Once coverage for the transplant is predetermined, Wells Fargo TPA will advise the Covered Plan Participant or the Covered Plan Participant's Physician of the coverage decision.

For covered transplants, and all related complications, the Plan will cover:

- Hospital and Physician expenses provided that such services will be paid in accordance with the same terms and conditions for care and treatment of any other covered Condition.
- Donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

Covered Plan Participants may call the Wells Fargo TPA Customer Service telephone number indicated in the Monroe County Group Health Plan Document or on the Covered Plan Participant's Identification Card in order to determine which Bone Marrow Transplants are covered under the Monroe County Group Health Plan Document.

Exclusion

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under the Monroe County Group Health Plan Document (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation or any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under the Monroe County Group Health Plan Document;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant which is not specifically listed in rule 59-B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for the Covered Plan Participant and/or the Covered Plan Participant's family to and from the approved facility; and
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Section 8 - General Exclusions

Introduction

The Monroe County Group Health Plan Document expressly excludes expenses for the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the Covered Services Section or any other section of the Monroe County Group Health Plan Document.

- **Adult Wellness** preventive care or routine screening Services, except as specified under the Benefit Maximums section in the Schedule of Benefits.

- **Arch Supports** shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, over-the-counter, custom-made or built-up shoes, cast shoes, sneakers, ready-made compression hose or support hose, or similar type devices/appliances regardless or intended use, except for therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

- **Assisted Reproductive Therapy (Infertility)** including, but not limited to, associated Services, supplies, and medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; Artificial Insemination (AI); embryo transport; surrogate parenting, donor semen and related costs including collection and preparation; and infertility treatment medication.

- **Autopsy** or postmortem examination services, unless specifically requested by Wells Fargo Third Party Administrator.

- **Complementary or Alternative Medicine** including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purifications therapies; traditional Oriental medicine including naturopathic medicine; environmental medicine including the field of clinical ecology; chelation therapy; thermography; mind-body interactions such as meditation, imagery, yoga, dance, and art therapy; biofeedback; prayer and mental healing; manual healing methods such as the Alexander technique, aromatherapy, Ayurvedic massage, craniosacral balancing, Feldenkrais method, Hellerwork, polarity therapy, Reichian therapy, reflexology, rolfing, shiatsu, traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

- **Complications of Non-Covered Services** including the diagnosis or treatment of any Condition which is a complication of a non-covered Health Care Service (e.g., Health Care Services to treat a complication of cosmetic surgery are not covered).

- **Contraceptive** medications, devices, appliances, or other Health Care Services when provided for contraception.

- **Cosmetic Services,** including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

- **Costs** related to telephone consultations, failure to keep a scheduled appointment, or completion of any form and/or medical information.

- **Custodial Care** and any service of a custodial nature, including and without limitation: Health Care Services primarily to assist in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; respite care; and provision of services which are for the sole purposes of allowing a family member or caregiver of a Covered Plan Participant to return to work.

- **Dental Care** or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, except as covered under the "Dental" Covered Services subsection; restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays, except as covered under the "Dental" Covered Services subsection. This exclusion does not apply to TMJ, wisdom tooth extraction, an Accidental Dental Injury and the Child Cleft Lip and Cleft Palate Treatment Services as described in the Covered Services Section.

- **Diabetic Equipment and Supplies** used for the treatment of diabetes which are otherwise covered under the Pharmacy Program.

- **Drugs**

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Covered Plan Participant's particular cancer in a Standard Reference Compendium or recommended for treatment of a Covered Plan Participant's particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

2. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.

3. Any drug which is indicated or used for sexual dysfunction (e.g., Cialis, Viagra) (except when drugs are being used for Medically Necessary treatment of organic impotence resulting from: treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence,

arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, epispadias, and exstrophy). The exception described in exclusion number one above does not apply to sexual dysfunction drugs excluded under this paragraph.

- **Experimental** or **Investigational Services** except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection.

- **Food and Food Products** prescribed or not, except as covered in the Enteral Formulas subsection of the "Covered Services" section.

- **Foot Care** which is routine, including any Health Care Service, in the absence of disease. This exclusion includes, but is not limited to: non-surgical treatment of bunions; flat feet; fallen arches; chronic foot strain; trimming of toenails corns, or calluses.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to a Covered Plan Participant's Effective Date or after the date the Covered Plan Participant's coverage terminates;

2. any Service to diagnose or treat any Condition resulting from or in connection with a Covered Plan Participant's job or employment;

3. any Health Care Services not within the service subsections described in the "Covered Services" section, any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;

4. any Health Care Services provided by a Physician or other health care Provider related to a Covered Plan Participant by blood and marriage;

5. any Health Care Services which is not Medically Necessary as determined by Wells Fargo TPAand/or KPHA and defined in the Monroe County Group Health Plan Document. The ordering of a Service by a health care Provider does not in itself make such Service Medically Necessary or a Covered Service;

6. any Health Care Service rendered at no charge;

7. expenses for claims denied because information requested was not received from a Covered Plan Participant regarding whether or not they have other coverage and the details of such coverage;

8. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:

    a) war or an act of war; whether declared or not;
    b) a Covered Plan Participants participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
    c) a Covered Plan Participant engaging in an illegal occupation;
    d) Services received at military or government facilities; or

e) Services received to treat a Condition arising out of a Covered Plan Participants service in the armed forces, reserves and/or National Guard;
f) Services that are not patient-specific, as determined solely by the Plan

9. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under the Monroe County Group Health Plan Document.

10. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group; or

11. Health Care Services that are not direct, hands-on, and patient specific, including, but not limited to the oversight of a medical laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, equipment, or laboratory technicians.

- **Genetic Screening** including the evaluation of genes of a Covered Plan Participant to determine if they are carriers of an abnormal gene that puts them at risk for a disease.

- **Hearing** aids (external or implantable aids) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair; and routine hearing Tests or Services necessary due to degenerative hearing loss not specifically caused by sickness, congenital defect or trauma.

- **Immunizations** except those covered under the Preventive Child Health Supervision Services or Adult Wellness Services subsections of the "Covered Services" section.

- **Maternity Services** rendered to a Covered Plan Participant who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal Maternity/Obstetrical Care, and Health Care Services rendered to the Covered Plan Participant acting as a Gestational Surrogate.

  For the definition of Gestational Surrogate and Gestational Surrogacy Contract see the Definitions section of the Monroe County Employee Group Health Plan Document.

- **Oral Surgery** except as provided under the "Covered Services" section.

- **Orthomolecular Therapy** including nutrients, vitamins, and food supplements.

- **Oversight of a medical laboratory** by a Physician or other health care Provider. "Oversight" as used in this exclusion shall include, but is not limited to, the oversight of:

1. the laboratory to assure timeliness, reliability, and/or usefulness of test results;

2. the calibration of laboratory machine or testing of laboratory equipment;

3. the preparation, review or updating of any protocol or procedure created or reviewed by a Physician or other health care Provider in connection with the operation of the laboratory; and

4. laboratory equipment or laboratory personnel for any reason.

- **Personal Comfort, Hygiene or Convenience Items** and Services deemed to be not Medically Necessary and not directly related to the Covered Plan Participant's treatment including, but not limited to:

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations
5. telephone charges;
6. take-home supplies;
7. travel expenses (other that Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, heated spas; pools; or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the "Covered Services" section of the Monroe County Group Health Plan Document.

- **Prescription Drug** Copayments, Coinsurance and Deductibles (if any), or any part thereof, the Covered Plan Participant is obligated to pay under the Prescription Drug Program.

- **Rehabilitative Therapies** provided on an inpatient or outpatient basis, except as provided in the Hospital, Inpatient Rehabilitation, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, and Spinal Manipulations subsections of the "Covered Services" section. Rehabilitative Therapies provided for the purpose of maintaining rather than improving the Covered Plan Participant's Condition are also excluded.

- **Reversal of Voluntary, Surgically-Induced Sterility** including the reversal of tubal ligations and vasectomies.

- **Sexual Reassignment, or Modification Services** including, but not limited to, any Health Care Services related to such treatment, such as psychiatric Services.

- **Smoking Cessation Programs** including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.

- **Sports-Related** devices and services used to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.

- **Training and Educational Programs**, or materials, including; but not limited to programs or materials for pain management and vocational rehabilitation, except as provided under the Diabetes Outpatient Self Management subsection of the "Covered Services" section.

- **Travel** or vacation expenses even if prescribed or ordered by a Provider.

- **Volunteer Services** or Services which would normally be provided free of charge and any charges associated with Deductible, Coinsurance, or Copayments (if applicable) requirements which are waived by a health care Provider.

- **Weight Control Services** including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition. This exclusion includes, but is not limited to, weight control/loss programs, appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment.

- **Wigs** and/or cranial prosthesis.

Section 9 - Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Plan, and who meets and continues to meet the eligibility requirements described in the Monroe County Group Health Plan Document, shall be entitled to apply for coverage under the Plan. These eligibility requirements are binding upon Covered Plan Participants and their eligible family members. No changes in the eligibility requirements will be permitted except as permitted by the Monroe County Group Health Plan Administrator. Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Eligible Employee as the legal guardian or appropriate adoption documentation described in the "Enrollment and Effective Date of Coverage" section.

Eligibility Requirements for Covered Employee

In order to be eligible to enroll as a Covered Employee, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

- The employee must be a bona fide employee of a Monroe County Employer participating in the Monroe County Group Health Plan;
- The employee must be actively working 25 hours or more per week on a regular basis;
- The employee must have completed the applicable waiting period of 60 days of continuous service (Waiting Period);
- The employee must meet any additional eligibility requirement(s) required by the Monroe County Group Health Plan Administrator.

Employees and qualified Dependents are eligible for coverage on the day following the 60th day of continuous service or Waiting Period.

Eligibility Requirements for Covered Retirees

An individual who meets the eligibility criteria specified below is an Eligible Retiree and is eligible to apply for coverage under this Monroe County Group Health Plan Document:

- A person who elects to continue or re-enroll in the Monroe County Group Health Plan at the time of their official retirement under the Florida Retirement System (FRS) and if not currently an Eligible Employee, that Monroe County was their last FRS employer prior to retirement. <u>If the Eligible Retiree fails to elect retiree coverage at time of retirement, waives retiree coverage or lets coverage lapse, the Eligible Retiree will permanently lose entitlement to enroll under the Monroe County Group Health Plan.</u>

AND

- meets one of the following requirements as established by the Board of County Commissioners Resolution No. 354-2003 – Retirement Eligibility Requirements for Group Health Insurance Coverage for Monroe County Employees:

1. Hire date prior to 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire under the FRS on, or after, the Normal Retirement date as described in Section 121.021 (29), F.S.; and covered under the Plan at retirement. Current contribution is HIS* for 10 years of service with FRS.

2. Hire date prior to 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire under the FRS at an Early Retirement date as described in Section 121.021 (30), F.S.; covered under the Plan at retirement; 60 years of age or age and years of service must satisfy Rule of 70** at time of retirement. Current contribution is HIS* for 10 years of service with FRS.

3. Hire date prior to 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire under the FRS at an Early Retirement date as described in Section 121.021 (30), F.S.; covered under the Plan upon retirement; NOT 60 years of age and age and years of service do not satisfy Rule of 70**. Current contribution is the departmental rate. Upon attaining either the age of 60 or satisfy Rule of 70** the contribution will change to the HIS* for 10 years of service with FRS.

4. Hire date on or after 10/01/01; a minimum of ten (10) years of full-time service with Monroe County; retire with the FRS as described in Section 121.021 (29) or 121.021 (30), F.S.; covered under the Plan upon retirement. Current contribution is the departmental rate.

5. Retire from FRS as described in Section 121.021 (29) or 121.021 (30), F.S.; less than ten (10) years of full-time service with Monroe County; covered under the Plan upon retirement. Current contribution is the departmental rate.

6. Former Eligible Employee with at least ten (10) years of full-time service with Monroe County; covered under the Plan upon termination of employment and fully vested under FRS who elected not to retire under FRS upon termination of employment with Monroe County, may elect to re-enroll under the Plan upon retirement under FRS, provided that Monroe County was their last FRS employer. Current contribution is the departmental rate.

***HIS - Health Insurance Subsidy per Section 112.363, Florida Statutes.**
****Rule of 70 – Eligible Retirees satisfy the Rule of 70 if their age, combined with the number of years of service with Monroe County totals 70 or more.**

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under the Plan:

1. The Covered Employee/Retiree's spouse under a legally valid existing marriage or Registered Domestic Partner;

2. A Covered Employee/Retiree's child, provided the child is under the age 19 and unmarried, except as provided below.

3. The Covered Employee/Retiree's child who:

   a. is under the age of 25 or is still within the Calendar Year in which he or she reaches age 25 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), and:

      i. is dependent upon the Covered Employee/Retiree for financial support; and

ii. is living in the household of the Covered Employee/Retiree or is a full-time or part-time student; or

b. is under the age of 30 or is still within the Calendar Year in which he or she reaches age 30 and who:

i. is unmarried and does not have a dependent;
ii. is a Florida resident or a full-time or part-time student;
iii. is not enrolled in any other health coverage policy or plan;
iv. is not entitled to benefits under Title XVII of the Social Security Act; and
v. when:

1. enrolling for the first time under the Covered Employee/Retiree's policy after age 25; or
2. re-enrolling after the end of the Calendar Year in which the child reaches the age of 25, with no gap in Creditable Coverage longer than 63 days.

c. in the case of a handicapped dependent child, such child is eligible to continue coverage, beyond the limiting age of 30, as a Covered Dependent if the dependent child is:

i. otherwise eligible for coverage under the Plan;
ii. incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
iii. chiefly dependent upon the Covered Employee/Retiree for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 30th birthday.

This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

or

2. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 25. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

As used in this Plan, the term "child" or "children" means:

1. Natural children;
2. Legally adopted children;
3. Children placed in your home for adoption pursuant to Chapter 23, Florida Statutes;
4. Stepchildren you are eligible to claim as dependents on your current federal tax return;
5. Foster children for whom you have been granted court-ordered temporary custody or other custody;
6. Children for whom you are legal guardian or have court-ordered temporary custody or other custody.

Note: If a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 25, obtains a dependent of their own (e.g., through birth or adoption), such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage. It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Section 10 - Enrollment and Effective Date of Coverage

Eligible Employees/Eligible Retirees and Eligible Dependents may enroll for coverage according to the provisions below.

Any Eligible Employee/Eligible Retiree or Eligible Dependent who is not properly enrolled will not be covered under the Monroe County Group Health Plan Document. Neither Wells Fargo TPA nor the Monroe County Group Health Plan Administrator will have any obligation whatsoever to any individual who is not properly enrolled.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. No. 110-173) requires Group Health Plans to share eligibility information pertaining to all Covered Plan Participants with the Centers for Medicare and Medicaid Services (CMS). This law was enacted to enable Group Health Plans and Medicare to more accurately identify those Participants enrolled in both the Plan and Medicare coverage and to expedite the appropriate coordination of benefits. In accordance with this requirement, complete eligibility information (including Dependent Social Security numbers) will be required at the time of enrollment in the Plan.

Any Employee/Retiree or Eligible Dependent who is eligible for coverage under the Monroe County Group Health Plan Document may apply for coverage according to the provisions set forth below.

Enrollment Forms/Electing Coverage

To apply for coverage, the Eligible Employee/Retiree must:

1. complete and submit, through the Plan Administrator (Benefits Office), the Enrollment Form;

2. provide any additional information needed to determine eligibility, at the request of Wells Fargo TPA or the Monroe County Group Health Plan Administrator;

3. pay any required contribution; and

4. complete and submit through the Monroe County Health Plan Administrator (Benefits Office), an Enrollment Form to add Eligible Dependents.

When making application for coverage, the Eligible Employee/Retiree must elect one of the types of coverage available under the Plan's program. Such types may include:

Employee/Retiree Only Coverage – This type of coverage provides coverage for the Covered Employee/Retiree only.

Employee/Retiree & Spouse Coverage – This type of coverage provides coverage for the Covered Employee/Retiree and their spouse under a legally valid existing marriage or Registered Domestic Partner.

Employee/Retiree & Child(ren) Coverage – This type of coverage provides coverage for the Covered Employee/Retiree and their covered child(ren) only.

Employee/Retiree & Family Coverage – This type of coverage provides coverage for the Covered Employee/Retiree and their Covered Dependents.

Contribution amounts are based on the type of coverage selected. These contributions amounts are set by the Monroe County Board of County Commissioners.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the period of time during which Eligible Employees are first eligible to enroll their Eligible Dependents. It starts on the Eligible Employee's initial date of hire and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which Eligible Employees and Eligible Retirees are given the opportunity to select coverage from among the alternatives included in the Plan's program. The period is established by the Monroe County Group Health Plan Administrator, occurs annually, and will take place when specified by Monroe County Group Health Plan Administrator.

Special Enrollment Period is the 30-day period of time immediately following a special circumstance during which an Eligible Retiree or Eligible Dependent may enroll for coverage. Special circumstances are described in the Special Enrollment Period subsection.

Employee Enrollment

All Eligible Employees will complete an Enrollment Form at time of hire and are enrolled in the Monroe County Group Health Plan (regardless of other coverage). The Effective Date will be the date specified by the Monroe County Group Health Plan Administrator (Benefits Office).

Annual Open Enrollment Period

During an Annual Open Enrollment Period Eligible Dependents (except special rules apply to Eligible Dependent child(ren) who have reached the end of the Calendar Year in which they become 25) who were not enrolled in the Plan during the Initial Enrollment Period or a Special Enrollment Period may be enrolled in the Plan. Eligible Employees and Eligible Retirees may also make coverage changes during this time. The effective date of coverage will be the date established by the Monroe County Group Health Plan Administrator.

Eligible Employees and Eligible Retirees who do not make changes to their coverage selection, during the Annual Open Enrollment Period will retain the coverage in effect unless the Eligible Retiree or the Eligible Dependent has a new opportunity to enroll due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

Note: The Annual Open Enrollment Period will only apply to Eligible Dependent child(ren) who have reached the end of the Calendar Year in which they become 25, but who have not reached the end of the Calendar Year in which they become 30, if the Eligible Dependent child(ren) had other Creditable Coverage, lost such Creditable Coverage and applied for coverage under this policy within 63 days of the loss of the prior Creditable Coverage.

Special Enrollment Period

An Eligible Retiree and/or Eligible Dependents may apply for coverage as a result of a special enrollment event. To apply for coverage, the Eligible Retiree and/or Eligible Dependents must complete the applicable Enrollment Form and forward it to the Monroe County Group Health Plan Administrator (Benefits Office) within 30 days of the date of the special enrollment event.

For the purposes of the Monroe County Group Health Plan Document, the following are the special enrollment events:

1. Eligible Dependents who lose their coverage under another group health benefit plan, or coverage under other health insurance, or COBRA continuation coverage that the Eligible Dependent was covered under at the time of initial enrollment provided the loss of other coverage under a group health plan or health insurance coverage was a result of termination of employment, reduction in the number of hours worked, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of a spouse, divorce, legal separation or employer contributions toward such coverage was terminated.

   Note: Loss of coverage for failure to pay any required contribution/premium on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

2. Eligible Employee/Retiree obtains an Eligible Dependent through marriage, established Domestic Partnership, birth, adoption or placement in anticipation of adoption.

3. Former Eligible Employee with at least ten (10) years of full-time service with Monroe County; covered under the Plan upon termination of employment and fully vested under FRS who elected not to retire under FRS upon termination of employment with Monroe County, must re-enroll under the Plan within 30 days of retirement under FRS, provided that Monroe County was their last FRS employer.

4. Pursuant to the Children's Health Insurance Program Reauthorization Act of 2009, a Dependent shall become eligible for enrollment under the Plan following the loss of the Dependent's eligibility for Participation in state Medicaid or Children's Health Insurance Program (CHIP) coverage. Following such a loss of eligibility, a Dependent special enrollment period shall commence on the date the Dependent loses eligibility for Medicaid or CHIP coverage or on the date the Dependent or Employee becomes eligible becomes eligible for premium assistance subsidy under Medicaid or CHIP. In accordance with federal law, this Dependent special enrollment period shall continue for a period of not less than sixty (60) days. (This is an exception to the previously stated thirty (30) day enrollment period allotted for other types of Dependent special enrollment qualifying events.)

The Effective Date of coverage as a result of a special enrollment event is the date of the special enrollment event (e.g., date of birth, date of marriage). Eligible Dependents who do not enroll during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (see the Dependent Enrollment subsection of this section for the rules relating to enrollment of Eligible Dependents of a Covered Plan Participant).

Note: The Special Enrollment Period will only apply to Eligible Dependent child(ren) who have reached the end of the Calendar Year in which they become 25, but who have not reached the end of the Calendar Year in which they become 30, if the Eligible Dependent child(ren) had other Creditable Coverage, lost such Creditable Coverage and applied for coverage under this policy within 63 days of the loss of the prior Creditable Coverage.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Covered Employee/Retiree. Below are special rules for certain Eligible Dependents.

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Employee/Retiree must submit an Enrollment Form to the Monroe County Group Health Plan Administrator (Benefits Office) during the 30-day period immediately following the date of birth. The Effective Date of coverage for the newborn child will be the date of birth.

If timely notice is given, no additional contribution will be charged for coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for a newborn child of the Covered Employee provides notice to the Monroe County Group Health Plan Administrator (Benefits Office) and an Enrollment Form is received within the 60-day period following the birth of the child and any applicable contribution is paid back to the date of birth.

If the newborn is not enrolled within sixty days of the date of birth, the newborn child will not be covered, and may only be enrolled under the Monroe County Group Health Plan Document during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

Note: Coverage for a newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 25 will automatically terminate 18 months after the birth of the newborn child. For a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 25, if the Covered Dependent child obtains a dependent of their own (e.g., through birth or adoption), such newborn child will not be eligible for this coverage and cannot enroll. Further, the Covered Dependent child will also lose his or her eligibility for this coverage.

Adopted Newborn Child – To enroll an adopted newborn child, the Covered Employee/Retiree must submit an Enrollment Form through the Monroe County Group Health Plan Administrator (Benefits Office) during the 30-day period immediately following the date of birth. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Employee/Retiree prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Employee/Retiree may be required to provide any information and/or documents that are deemed necessary in order to administer this provision.

If timely notice is given, no additional contribution will be charged for coverage of the adopted newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for an adopted newborn child if the Covered Employee/Retiree provides notice to the Monroe County Group Health Plan Administrator (Benefits Office) and an Enrollment Form is received within the 60-day period following the birth of the adopted newborn child and any applicable contribution is paid back to the date of birth.

If the adopted newborn child is not enrolled within sixty days of the date of birth, the adopted newborn child will not be covered, and may only be enrolled under the Monroe County Group Health Plan Document during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

If the adopted newborn child is not ultimately placed in the residence of the Covered Employee/Retiree, there shall be no coverage for the adopted newborn child. It is the responsibility of the Covered Employee/Retiree to notify the Monroe County Group Health Plan Administrator within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in the residence.

Adopted/Foster Children – To enroll an adopted or Foster Child, other than a newborn child, the Covered Employee/Retiree must submit an Enrollment Form during the 30-day period immediately following the date of placement. The Effective Date for an adopted or Foster child (other than an adopted newborn child) will be the date such adopted or Foster child is placed in the residence of the Covered Employee/Retiree in compliance with applicable law. Any Pre-existing Condition exclusionary period will not apply to an adopted child but will apply to a Foster child. The Covered Employee/Retiree may be required to provide any information and/or documents deemed necessary in order to properly administer this section.

In the event the Monroe County Group Health Plan Administrator is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as the Covered Employee/Retiree provides notice to the Monroe County Group Health Plan Administrator, and the Benefits Office receives the Enrollment Form within 60 days of the placement. If the adopted or Foster Child is not enrolled within sixty days of the date of placement, the adopted or Foster child will not be covered, and may only be enrolled under the Monroe County Group Health Plan Document during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period. For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted Child. Proof of final adoption must be submitted to the Monroe County Group Health Plan Administrator (Benefits Office). It is the responsibility of the Covered Employee/Retiree to notify the Monroe County Group Health Plan Administrator if the adoption does not take place. Upon receipt of this notification, coverage for the child will be terminated as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Employee/Retiree's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Employee/Retiree to notify the Monroe County Group Health Plan Administrator that the Foster Child is no longer in the Covered Employee/Retiree's care. Upon receipt of this notification, coverage for the child will be terminated on the date of the Covered Employee/Retiree's status as a foster parent terminated.

Marital Status – The Covered Employee/Retiree may apply for the coverage of an Eligible Dependent due to a legally valid marriage or Registered Domestic Partner. To apply for coverage, the Covered Employee/Retiree must complete the Enrollment Form through Monroe County Group Health Plan Administrator (Benefits Office). The Covered Employee/Retiree must make application for enrollment within 30 days of the marriage or the registration of the Domestic Partnership. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage; if enrolled as a result of a Registered Domestic Partnership is the date of the registration.

Qualified Medical Child Support Orders – The Plan will provide benefits as required by any Qualified Medical Child Support Order (MCSO). A MCSO can be either: 1) A Qualified Medical Child Support Order (MCSO) that satisfies the requirements of Section 609(a) of ERISA; or 2) A National Medical Support Notice (NMSN) that satisfies the requirements of Section 1908 of the Social Security Act. Upon receipt of a MCSO or NMSN by a Covered Employee/Retiree notification must be given to the Monroe County Group Health Plan Administrator (Benefits Office) within 31 days of receipt. The Covered Employee/Retiree will need to provide any reasonable information or assistance to the Monroe County Group Health Plan Administrator (Benefits Office) in connection with the MCSO.

Upon receipt of a MCSO or NMSN the Monroe County Group Health Plan Administrator (Benefits Office) will:

1. Notify the Covered Employee/Retiree and each Alternate Recipient, in writing, of the Plan's procedure for determining if the order or notice is a QMCSO;
2. Make a determination of the qualified status of the order or notice within a reasonable time;
3. Notify the Covered Employee/Retiree and each Alternate Recipient, in writing, of the Plan's determination; and
4. If the notice is a NMSN, notify the applicable government agency of its determination within a reasonable period of time not (not to exceed 40 business days).

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If the notice is an NMSN, the Monroe County Group Health Plan Administrator (Benefits Office) will also notify the government agency that issued the notice:

1. Whether or not coverage is available to the Alternate Recipient;
2. Whether or not the Alternate Recipient is enrolled;
3. What coverage options are available to the Alternate Recipient;
4. The effective date of coverage; and
5. What steps the custodial parent (or agency) must take to obtain coverage.

Once the Monroe County Group Health Plan Administrator (Benefits Office) determines that the order or notice is a QMCSO, the Monroe County Group Health Plan Administrator (Benefits Office) will determine the effective date of coverage and enroll each Alternate Recipient as required by the order and make any necessary payroll deductions from the Covered Employee. Covered Retirees would make monthly premium payments.

Other Provisions Regarding Enrollment and Effective Date of Coverage

Individuals who are rehired as employees of Monroe County Board of County Commissioners; Clerk of the Circuit Court; Land Authority; Property Appraiser; Sheriff's Department; Supervisor of Elections and Tax Collector are considered newly hired employees for purposes of this section. The provisions of the Monroe County Group Health Plan Document which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period are applicable to rehired employees and their Eligible Dependents.

Section 11 - Termination of Coverage

Termination of a Covered Employee's/Retiree's Coverage

A Covered Plan Participant's coverage under the Monroe County Group Health Plan Document will automatically terminate at 11:59:59 p.m.:

1. on the date the Monroe County Group Health Plan terminates;

2. on the day the Covered Employee terminates employment;

3. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or

4. The date ending the period for which contributions (if required) have been paid.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage under the Monroe County Group Health Plan Document will automatically terminate at 11:59:59 p.m.:

1. on the date the Monroe County Group Health Plan terminates:

2. on the date the Covered Dependent's coverage terminates for any reason;

    a. as further clarification for purposes of this subsection, a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 25, but who has not reached the end of the Calendar Year in which the Covered Dependent child becomes 30 will lose coverage if the Covered Dependent child incurs any of the following:

        i. marriage;
        ii. no longer resides in Florida or is no longer a full-time or part-time student;
        iii. obtains a dependent (e.g., through birth or adoption);
        iv. obtains other coverage; or
        v. on the date of termination of the Covered Employee's coverage.

3. on the last day of the first month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Employee/Retiree);

4. on the date specified by the Monroe County Group Health Plan Administrator that the Covered Dependent's coverage terminates; or

5. on the date the Monroe County Group Health Plan Administrator specifies that the Covered Dependent's coverage is terminated for cause.

6. Pursuant to the provisions of H.R. 2851 ("Michelle's Law"), an Eligible Dependent Child's non-attendance at a secondary school, college or university due to a Medically Necessary leave of absence will not cause termination of participation in the Plan until the date that is the earlier of:

a. One (1) year after the first day of commencement of the leave of absence, provided:

   (1) The Eligible Dependent Child was enrolled in the Plan on the basis of being a Full Time Student immediately before the first day of the leave of absence and:
   (2) The Monroe County Group Health Plan Administrator has received written certification by an attending Physician which states the Eligible Dependent Child is suffering from a serious illness or injury and the leave of absence is Medically Necessary; or

b. The date on which participation would otherwise terminate under the terms of the Monroe County Group Health Plan Document.

Note: An Eligible Dependent Child whose participation under the Plan is continued under this section will be entitled to the same benefits to which the Eligible Dependent Child was entitled prior to the Medically Necessary leave of absence. If Monroe County Group Health Plan Document changes occur during the Eligible Dependent Child's Medically Necessary leave of absence, the provisions of this section will apply to the changed coverage as if it were the previous coverage.

In the event a Covered Employee wishes to delete a Covered Dependent from coverage, an Enrollment Form must be forwarded to the Monroe County Group Health Plan Administrator (Benefits Office).

In the event a Covered Employee wishes to terminate a spouse's coverage, (e.g., in the case of divorce), or a Registered Domestic Partner (e.g., dissolution of partnership), the Covered Employee must submit an Enrollment Form to the Monroe County Group Health Plan Administrator (Benefits Office), prior to the requested termination date or within 10 days of the date the divorce is final or 30 days after the dissolution of domestic partnership, whichever is applicable.

Termination of a Covered Plan Participant's Coverage for Cause

In the event any of the following occurs, Monroe County Group Health Plan Administrator may terminate a Covered Plan Participant's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits; or
2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed, by a Covered Plan Participant or on their behalf.

Cessation of Active Work

Approved Medical Leave – If an Eligible Employee ceases Active Work due to illness, injury or pregnancy their Employer in its sole discretion may approve a medical leave of absence. Coverage for the Eligible Employee will continue under the Plan, but for no longer than 6 (six) months from the date the approved medical leave begins. Coverage of Eligible Dependents will continue during this time provided required premiums are continued to be paid. Notification of all approved medical leave must be provided to the Monroe County Group Health Administrator (Benefits Office) by the Employer. The notification should contain the date of when the leave began and when it will end. An Eligible Employee who has been on an approved medical leave must return to active work for a minimum of 30 days after the approved medical leave ends. In the event an Eligible Employee on an approved medical leave does not return to active work at the end of the leave, the Eligible Employee will be required to reimburse the Plan for the health benefit premiums paid during the leave to continue coverage.

***Note:** When an Eligible Employee fails to return to active work because of the continuation, recurrence, or onset of either a serious health condition of the Eligible Employee or an Eligible Employee's family member the Plan will not recover the health benefit premium payments made on the Eligible Employee's behalf during the approved medical leave. The Monroe County Group Health Plan Administrator (Benefits Office) may require medical certification of the Eligible Employee's or the Eligible Employees family member's serious health condition.

Rehire/Reinstatement – If subsequent to termination of coverage an Eligible Employee is rehired or reinstated as an Eligible Employee the Eligible Employee must meet the eligibility requirements in the Eligibility for Coverage section. However, the Plan allows a grace period of 2 days following the date of termination of coverage during which an Eligible Employee may be rehired or reinstated without penalty.

Active Military Duty – Return from active military duty by a former Eligible Employee of two weeks or longer who is rehired or reinstated will be treated as if the Eligible Employee were on an approved leave of absence for purposes of eligibility under the Plan. The Plan's waiting period or preexisting condition exclusion period will not be applicable.

Notice of Termination

It is the Monroe County Group Health Plan Administrator's responsibility to immediately notify a Covered Plan Participant in the event his or her coverage is terminated for any reason.

Certification of Creditable Coverage

In the event coverage terminates for any reason, a written certification of Creditable Coverage will be issued to the individual losing coverage.

The certification of Creditable Coverage will indicate the period of time the individual was enrolled under the Plan. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time the individual had prior Creditable Coverage.

Upon request, another certification of Creditable Coverage will be sent to the individual within a 24- month period after termination of coverage.

The succeeding carrier will be responsible for determining if coverage meets the qualifying Creditable Coverage guidelines (e.g., no more than a 63-day break in coverage).

Section 12 - Continuing Coverage Under COBRA

Federal continuation of coverage law is known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA Covered Plan Participants may be entitled to continue coverage for a limited period of time, if they meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

A Covered Plan Participant must contact the Monroe County Group Health Plan Administrator (Benefits Office) to determine their entitlement to COBRA continuation coverage. The Monroe County Group Health Plan Administrator is solely responsible for meeting all of the employer's obligations under COBRA, including the obligation to notify all Covered Plan Participants of their rights under COBRA. If a Covered Plan Participant fails to meet the obligations under COBRA, the Monroe County Group Health Plan will not be liable for any claims incurred by a Covered Plan Participant after termination of coverage.

A summary of COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below.

Under COBRA:

1. A Covered Plan Participant may elect to continue coverage for a period not to exceed 18 months***** in the case of:
    a) termination of employment of the Covered Employee other than for gross misconduct; or
    b) reduced hours of employment of the Covered Employee.

***Note:** A Covered Plan Participant is eligible for an 11 month extension of the 18 month COBRA continuation coverage option above (to a total of 29 months) if the Covered Plan Participant is totally disabled as defined by the Social Security Administration (SSA) at the time of termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Plan Participant must supply notice of the disability determination to the Monroe County Group Health Plan Administrator (Benefits Office) within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. A Covered Eligible Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
    a) the Covered Employee's entitlement to Medicare;
    b) divorce of the Covered Employee;
    c) dissolution of Domestic Partnership of the Covered Employee/Retiree;
    c) death of a Covered Employee or Covered Retiree*****
    d) the employer filed bankruptcy (subject to bankruptcy court approval); or
    e) a dependent child may elect the 36 month extension if the dependent child ceases to be an Eligible Dependent under the terms of the Monroe County Group Health Plan coverage.

***Note:** Upon the death of a Covered Retiree the Surviving Spouse may continue coverage under the Monroe County Group Health Plan provided: 1) they do not remarry; and 2) they make timely payment of any required contribution. It is the sole responsibility of the Surviving Spouse to notify the Monroe County Group Health Plan Administrator (Benefits Office) of a change in their marital status.

Children born to or placed for adoption with the Covered Employee during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

Additional requirements applicable to continuation of coverage under COBRA are set forth below:

1. Monroe County Group Health Plan Administrator (Benefits Office) must notify all Covered Plan Participants of the continuation of coverage rights under COBRA within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, or the failure of a Covered Dependent child to meet eligibility requirements, the Covered Plan Participant must notify the Monroe County Group Health Administrator (Benefits Office), in writing, within 60 days of any of these events. Monroe County Group Health Plan Administrator's 14-day notice requirements runs from the date of the receipt of such notice.

2. A Covered Plan Participant must elect to continue the coverage within 60 days of the later of:

    a) the date that the coverage terminates: or
    b) the date the notification of continuation of coverage rights is sent by the Monroe County Group Health Plan Administrator.

3. COBRA coverage will terminate if the Covered Plan Participant becomes covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-Existing Condition that would affect the Covered Plan Participant's coverage.

4. COBRA coverage will terminate if the Covered Plan Participant becomes entitled to Medicare.

5. If a Covered Plan Participant is totally disabled and elects to extend the continuation of coverage, such extension of coverage may not continue for more than 30 days after determination by the Social Security Administration that the Covered Plan Participant is no longer disabled. The Covered Plan Participant must inform Monroe County Group Health Plan Administrator (Benefits Office) of the Social Security Administration's determination within 30 days of such determination.

6. A Covered Plan Participant must meet all contribution requirements, and all other eligibility requirements described in COBRA, and to the extent not inconsistent with COBRA, in the Monroe County Group Health Plan Document.

7. COBRA coverage will terminate on the date the Monroe County Group Health Plan ceases to provide group health coverage to its employees.

An election by a Covered Employee or Covered Dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that Covered Employee or Covered Dependent spouse, unless otherwise specified in the election form.

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Monroe County Group Health Plan Document shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Monroe County Group Health Plan Document.

Section 13 - Conversion Privilege

Eligibility Criteria for Conversion

Covered Plan Participants are entitled to apply for an individual insurance conversion policy (hereinafter referred to as a "converted policy" or "conversion policy") if:

1. they were continuously covered for at least three months under the Monroe County Group Health Plan D, and/or under another group policy that provided similar benefits immediately prior to the Monroe County Group Health Plan; and

2. their coverage was terminated for any reason, including discontinuance of the Plan in its entirety and termination of continued coverage under COBRA.

The Covered Plan Participant must notify the Plan Administrator (Benefits Office) in writing or by telephone if he or she is interested in a conversion policy. Within 14 days of such notice, a conversion policy brochure and outline of coverage will be mailed to the Covered Plan Participant. The brochure contains easy steps to follow to obtain a Conversion Application.

Note: The conversion policy must be applied within 31 days after the date health coverage ends. In the event an application is not received within 31 days, the converted policy application will be denied and the individual will not be entitled to a converted policy.

Additionally, a Covered Plan Participant who loses coverage is not entitled to a converted policy if:

1. he or she is eligible for or covered under the Medicare program;

2. he or she failed to pay, on a timely basis, the contribution required for coverage under the Plan;

3. The Plan was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, which provides benefits similar to the benefits provided under the Monroe County Group Health Plan Document.

Neither the Plan nor Wells Fargo TPA has any obligation to notify individuals losing coverage of this conversion privilege when coverage terminates nor at any other time. It is each Covered Plan Participant's sole responsibility to exercise this conversion privilege by notifying the Plan Administrator (Benefits Office) in writing or by telephone if he or she is interested in a conversion policy within 31 days of the termination of their coverage under the Monroe County Group Health Plan Document. The converted policy may be issued without evidence of insurability and shall be effective the day following the day coverage under the Monroe County Group Health Plan terminated.

Note: The conversion policies are not a continuation of coverage under COBRA or any other states' similar laws.

Section 14 - Extension of Benefits

Extension of Benefits

In the event the Plan is terminated, coverage will not be provided under the Monroe County Group Health Plan Document for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire Group Health Plan is terminated. The extension of benefits described in this section does not apply when an individual's coverage terminates if the Plan remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is each individual's sole responsibility to provide acceptable documentation showing that he or she is entitled to an extension of benefits.

1. In the event an individual is totally disabled on the termination date of the Plan as a result of a specific Accident or illness incurred while the Covered Plan Participant was covered under the Plan, as determined by the Plan Administrator, a limited extension of benefits will be provided under the Plan for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. In any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Plan.

For purposes of this section, an individual will be considered "totally disabled" only if, in Wells Fargo TPA or Monroe County Group Health Plan Administrator's opinion, he or she is unable to work at any gainful job for which he or she is suited by education, training, or experience, and he or she requires regular care and attendance by a Physician. A Covered Plan Participant is considered totally disabled only if, in Wells Fargo TPA or Monroe County Group Health Plan Administrator's opinion, he or she is unable to perform those normal day-to-day activities which he or she would otherwise perform and he or she requires regular care and attendance by a Physician.

2. In the event an individual is receiving covered dental treatment as of the termination date of the Plan a limited extension of such covered dental treatment will be provided under the Monroe County Group Health Plan Document if:

    a) a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while the individual was covered under the Plan;
    b) dental procedures other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and
    c) the dental procedures were performed within 90 days after the Plan terminated.

This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Monroe County Group Health Plan or on the date the individual become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. The individual is not required to be totally disabled in order to be eligible for this extension of benefits.

Please refer to the Dental Care subsection of the "Covered Services" section for a description of the dental care Services covered under the Monroe County Group Health Plan Document.

3. In the event an individual is pregnant as of the termination date of the Plan, a limited extension of the maternity expense benefits included in the Monroe County Group Health Plan Document will be available, provided the pregnancy commenced while the pregnant individual was covered under the Plan as determined by Wells Fargo TPA or the Monroe County Group Health Plan Administrator. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. The individual is not required to be totally disabled in order to be eligible for this extension of benefits.

Section 15 - Medicare Coverage/Medicare Secondary Payer Provisions

Active Employees

When an active Covered Plan Participant becomes covered under Medicare and continues to be eligible and covered under the Monroe County Group Health Plan Document, coverage under the Monroe County Group Health Plan Document will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, coverage under the Monroe County Group Health Plan Document will be secondary to any Medicare benefits. To the extent the benefits under the Monroe County Group Health Plan Document are primary, claims for Covered Services should be filed with Wells Fargo TPA first. If an Eligible Employee or any of their eligible dependents who are covered under the Plan and Medicare, benefits from the Plan will coordinate with any other benefits received and total benefits payable will not exceed 100% of the Allowed Amount.

It is important for the Covered Plan Participant to enroll in Medicare as soon as the Covered Plan Participant becomes eligible.

Retired Employees

Retirees, their eligible spouses, or a surviving spouse enrolled in Medicare, Medicare will be pay benefits for the covered individual first and the Plan will pay benefits second. The total benefits paid will never be more than 100% of the Allowed Amount. **Once eligible, retirees and their spouses should enroll in Medicare Parts A and B. The Plan will pay as the secondary on all claims received from Medicare eligible Covered Plan Participants who are retired.**

Covered Plan Participants covered under COBRA who become eligible for Medicare will no longer be eligible to continue coverage.

Individuals With End Stage Renal Disease

<u>If a Covered Plan Participant turns 65 or becomes eligible for Medicare due to End Stage Renal Disease ("ESRD"), the Covered Plan Participant must immediately notify the Monroe County Group Health Plan Administrator (Benefits Office).</u>

If a Covered Plan Participant becomes entitled to Medicare coverage because of ESRD, coverage under the Monroe County Group Health Plan Document will be provided on a primary basis for 30 months beginning with the earlier of:

1. the month in which the Covered Plan Participant became entitled to Medicare Part "A" ESRD benefits; or
2. the first month in which the Covered Plan Participant would have been entitled to Medicare Part "A" ESRD benefits if a timely application has been made.

If Medicare was primary prior to the time a Covered Plan Participant became eligible due to ESRD, then Medicare will remain primary (i.e., retirees and/or their spouses or registered domestic partners over the age of 65). Also, if coverage under the Monroe County Group Health Plan Document was primary prior to ESRD entitlement, then coverage hereunder will remain primary for the ESRD coordination period. If a Covered Plan Participant becomes eligible for Medicare due to ESRD, coverage will be provided, as described in this section, on a primary basis for 30 months.

Disabled Active Individuals

If an active Covered Plan Participant is entitled to Medicare coverage because of a disability other than ESRD, Medicare benefits will be secondary to the benefits provided under the Monroe County Group Health Plan Document provided that Monroe County Board of County Commissioners employed at least 100 or more full-time or part-time employees.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions related to Medicare beneficiaries who are covered under the Monroe County Group Health Plan Document.
2. Wells Fargo TPA will not be liable to the Plan or to any individual covered under the Monroe County Group Health Plan Document on account of any nonpayment of primary benefits resulting from any failure of performance on Monroe County Group Health Plan Administrator's obligations as described in this section.

Section 16 - Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided under the Monroe County Group Health Plan Document.

COB determines the manner in which expenses will be paid when a Covered Plan Participant is covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is the Covered Plan Participants responsibility to provide to Wells Fargo TPA and the Monroe County Group Health Plan Administrator information concerning any duplication of coverage under any other health plan, program, or a Covered Plan Participant may have. This means the Covered Plan Participant must notify Wells Fargo TPA and the Monroe County Group Health Plan Administrator (Benefits Office) in writing if there is other applicable coverage or if there is not. Covered Plan Participants may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Services received. If the information is not received, claims may be denied and the Covered Plan Participant will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies which may be subject to COB include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group or non-group health insurance, group-type self-insurance, or HMO plan;

2. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage with which the law permits coordination of benefits;

3. Medicare, as described in "Medicare Coverage/Medicare Secondary Payer Provisions" section; and

4. to the extent permitted by law, any other government sponsored health insurance program.

The amount of payment, if any, when benefits are coordinated under this section, is based on whether or not the benefits under the Monroe County Group Health Plan Document are primary. When primary, payment will be made for Covered Services without regard to coverage under other plans. When the benefits under the Monroe County Group Health Plan Document are not primary, payment for Covered Services may be reduced so that total benefits under all plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. **In the event that the primary payer's payment exceeds the Allowed Amount, no payment will be made for such Services under the Monroe County Group Health Plan Document.**

The following rules shall be used to establish the order in which benefits under the respective plans will be determined:

1. When an individual is covered as a Covered Dependent and the other plan covers the individual as other than a dependent, the Plan will be secondary.

2. When the Plan covers a dependent child whose parents are not divorced:

    a) the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or
    b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than the Plan, the Plan will be secondary.
3. When the Plan covers a dependent who parents are divorced:

a) if the parent with custody is not remarried, the plan of the parent with custody is primary;

b) if the parent with custody has remarried, the plan of the parent with custody is primary; the stepparent's plan is secondary; and the plan of the parent without custody pays last;

c) regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.

4. When the Plan covers a dependent child and the dependent child is also covered under another plan:

   a) the plan of the parent who is neither laid off nor retired will be primary; or

   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the Covered Plan Participant the longest shall be primary.

6. If the Covered Plan Participant is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:

   a) first, the plan covering the person as an employee, or as the employee's Dependent; and

   b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

7. If the other plan does not have rules that establish the same order of benefits as under the Monroe County Group Health Plan Document, the benefits under the other plan will be determined primary to the benefits under the Monroe County Group Health Plan Document.

Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in *Florida Statutes* Section 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

Coordination of Benefits Exclusion

Prescription Drug Program Copayments, Coinsurance and Deductible, or any part thereof, the Covered Plan Participant's are obligated to pay under any plan or policy.

Non-Duplication of Government Programs and Workers' Compensation

The benefits under the Monroe County Group Health Plan Document shall not duplicate any benefits Covered Plan Participant are entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Workers' Compensation to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 17 - Subrogation, Right of Reimbursement and Equitable Lien

Subrogation

The Plan Administrator has rights of subrogation, which helps the Plan Administrator to continue providing cost-effective healthcare benefits.

In the event payment is made under the Monroe County Group Health Plan Document to or on behalf of a Covered Plan Participant for any claim in connection with or arising from a Condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, the Plan Administrator to the extent of any such payment, shall be subrogated, i.e., shall succeed, to all causes of action and all rights of recovery that the Covered Plan Participant may have against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated. Wells Fargo TPA may recover, on behalf of the Plan Administrator, the amount of any payments made on behalf of a Covered Plan Participant minus a pro rata share for any costs and attorney fees incurred by a Covered Plan Participant in pursuing and recovering damages. Wells Fargo TPA may subrogate, on behalf of the Plan Administrator, against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although the Plan Administrator may, but is not required, to take into consideration any special factors relating to the Covered Plan Participant's specific case in resolving the subrogation claim, the Plan Administrator will have the first right of recovery out of any recovery or settlement the Covered Plan Participant is able to obtain even if the Covered Plan Participant or Covered Plan Participant's or their attorney believes that the Covered Plan Participant has not been made whole for his/her losses or damages by the amount of the recovery or settlement.

The Covered Plan Participant is required to:

- Provide information pertaining to litigation and settlement, including settlement negotiations;
- Provide any assistance necessary to allow the Plan Administrator and/or Wells Fargo TPA to enforce its right to subrogation or reimbursement;
- Notify the Plan Administrator and/or Wells Fargo TPA before entering into any settlement negotiations with any third party and prior to executing any settlement agreement with the third party; and
- Obtain the consent of Wells Fargo TPA prior to entering into any settlement agreement with the third party.

No settlement agreement, waiver, or release of liability that you execute without notice to Wells Fargo TPA will be valid or binding on Wells Fargo TPA or the Plan Administrator.

Right of Reimbursement

If any payment under the Monroe County Group Health Plan Document is made to or on behalf of a Covered Plan Participant with respect to an injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, BOCC and/or the Plan will have a right to be reimbursed by the Covered Plan Participant (out of any settlement or judgment proceeds recovered by the Covered Plan Participant) one dollar ($1.00) for each dollar paid under the terms of the Monroe County Group Health Plan Document minus a pro rata share of any costs and attorney fees incurred in pursuing and recovering such proceeds.

The BOCC and/or the Plan's right of reimbursement will be in addition to any subrogation right or claim available to the BOCC, and the Covered Plan Participant must execute and deliver such instruments or papers pertaining to

any settlement or claim, settlement negotiations, or litigation as may be requested by Wells Fargo TPA on behalf of the BOCC and/or the Plan, to exercise the BOCC and/or the Plan's right of reimbursement hereunder. Covered Plan Participant's or their lawyer must notify Wells Fargo TPA, by certified or registered mail, if a Covered Plan Participant intends to claim damages from someone for injuries or illness. A Covered Plan Participant must do nothing to prejudice the BOCC and/or the Plan's right of reimbursement hereunder and no waiver, release of liability, or other documents executed by the Covered Plan Participant, without notice to and consent of Wells Fargo TPA acting on behalf of the BOCC, will be binding upon the BOCC.

Equitable Lien

The Plan shall have an equitable lien against any rights the Covered Plan Participant may have to recover any payments made by the Plan from any other party, including an insurer or another group health plan. Recovery shall be limited to the amount of reimbursable payments made by the Plan. The equitable lien also attaches to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Medical Services prior to a determination that the Covered Medical Services arose out of and in the course of employment. Payment by workers compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anybody (including, but not limited to, the Covered Plan Participant, the Covered Plan Participant's attorney, and/or trust) as a result of an exercise of the Covered Plan Participant's right of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Monroe County Group Health Plan Administrator, the Plan may reduce any future Covered Medical Services otherwise available to the Covered Plan Participant under the Plan by an amount up to the total amount of reimbursable payments made by the Plan that is subject to the equitable lien.

General Provisions – The following provisions shall apply to the Plan's right of subrogation, reimbursement and creation of an equitable lien. The subrogation, reimbursement, and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Plan Participant as a result of the injuries sustained, including but not limited to:

1. any no-fault insurance;
2. medical benefits coverage under any automobile liability plan. This includes the Covered Plan Participant's plan or any third party's policy under which the Covered Plan Participant is entitled to benefits;
3. under-insured or uninsured motorist coverage;
4. any automobile Medical Payments and Personal Injury Protection benefits; and
5. any third party's liability insurance

In addition:

1. The Plan may make total payments that exceed the maximum amount to which the Covered Plan Participant is entitled at any time under the Plan. In the event of such payments the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.

2. The Plan provides that recovery of excess amounts may include a reduction from future benefit payments available to the Covered Plan Participant under the Plan of an amount up to the aggregate amount of reimbursable payments that have not been reimbursed to the Plan.

3. The provisions of the Monroe County Group Health Plan Document concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

4. The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Monroe County Group Health Plan Administrator in the exercise of its sole discretion.

5. The Covered Plan Participant agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Monroe County Group Health Plan Administrator or its agent(s) may request. Also, the Covered Plan Participant agrees to furnish any other information as may be requested by the Monroe County Group Health Plan Administrator or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Monroe County Group Health Plan Administrator from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Monroe County Group Health Plan Document. Any excess after 100 percent reimbursement of the Plan may be divided up between the Covered Plan Participants and their attorney if applicable. The Covered Plan Participant agrees to take no action which in any way prejudices the right of the Monroe County Health Plan Document.

6. The Monroe County Group Health Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

7. If the Covered Plan Participant takes no action to recover money from any source, then the Covered Plan Participant agrees to allow the Plan to initiate its own direct action for reimbursement.

Section 18 - Claims Processing

Introduction

This section is intended to:

- Help the Covered Plan Participant understand what the Covered Plan Participant or the Covered Plan Participant's treating Providers must do, under the terms of the Monroe County Group Health Plan Document, in order to obtain payment for expenses for Covered Services they have rendered or will render to the Covered Plan Participant; and

- Provide the Covered Plan Participant with a general description of the applicable procedures that will be used for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying the Covered Plan Participant when benefits are denied.

Under no circumstances will Wells Fargo TPA be held responsible for, nor will Wells Fargo TPA accept liability relating to, the failure of the Monroe County Group Health Plan Administrator to: 1) comply with any applicable disclosure requirements; 2) provide the Covered Plan Participant with a Monroe County Group Health Plan Document; or 3) comply with any other legal requirements. The Covered Plan Participant should contact Wells Fargo TPA or the Monroe County Group Health Plan Administrator (Benefits Office) with questions relating to the Monroe County Group Health Plan Document. The Plan Administrator is the BOCC (Benefits Office).

Types of Claims

For purposes of the Monroe County Group Health Plan Document there are three types of claims: 1) Pre-Service Claims; 2) Post-Service Claims; and 3) Claims Involving Urgent Care. It is important that the Covered Plan Participant become familiar with the types of claims that can be submitted to Wells Fargo TPA and the timeframes and other requirements that apply. This section defines and describes the three types of claims that may be submitted to Wells Fargo TPA.

Post-Service Claims

<u>How to File a Post-Service Claim</u>

Experience shows that the most common type of claim Wells Fargo TPA will receive from the Covered Plan Participant or the Covered Plan Participant's treating Providers will likely be Post-Service Claims.

Most PPO Providers will file Post-Service Claims for services rendered to a Covered Plan Participant. In the event a Provider who renders services to a Covered Plan Participant does not file a Post-Service Claim for such services, it is the Covered Plan Participant's responsibility to file it with Wells Fargo TPA.

Wells Fargo TPA must receive a Post-Service Claim within 90 days of the date the Health Care Service was rendered or, if it was not reasonably possible to file within such 90-day period, as soon as possible. In any event, no Post-Service Claim will be considered for payment if Wells Fargo TPA does not receive it at the address indicated on the Covered Plan Participant's ID Card within one year of the date the service was rendered unless the Covered Plan Participant was legally incapacitated.

For a Post-Service Claim, Wells Fargo TPA must receive an itemized statement from the health care Provider for the service rendered along with a completed claim form. The itemized statement must contain the following information:

1. the date the service was provided;
2. a description of the service including any applicable procedure code(s);
3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the Provider's name and address;
6. the name of the individual who received the service; and
7. the Covered Employee's name and group number as they appear on the ID Card.

The itemized statement and claim for must be received by Wells Fargo TPA at the address indicated on the Covered Plan Participant's ID Card.

Note: Please refer to the Prescription Drug Program under the Schedule of Benefits Section for information on processing of prescription drug claims.

The Processing of Post-Service Claims

Wells Fargo TPA will use its best efforts to pay, contest, or deny all Post-Service Claims for which Wells Fargo TPA has all of the necessary information, as determined by Wells Fargo TPA. Post-Service Claims will be paid, contested, or denied within the timeframes described below.

- Payment for Post-Service Claims – When payment is due under the terms of the Monroe County Group Health Plan Document, Wells Fargo TPA will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, Wells Fargo TPA will use its best efforts to pay (in whole or in part) for paper Post-Service Claims within 30 days of receipt. If Wells Fargo TPA is unable to determine whether the claim or a portion of the claim if payable because more or additional information is needed, Wells Fargo TPA may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims – In the event Wells Fargo TPA contests an electronically submitted Post-Service Claim, or a portion of such a claim, Wells Fargo TPA will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event Wells Fargo TPA contests a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, Wells Fargo TPA will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that Wells Fargo TPA reasonably expects to notify the Covered Plan Participant of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If Wells Fargo TPA requests additional information, Wells Fargo TPA must receive it within 45 days of the request for the information. **If Wells Fargo TPA does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in the possession of Wells Fargo TPA at the time and may be denied.** Upon receipt of the requested information, Wells Fargo TPA will use its

best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- Denial of Post-Service Claims – In the event Wells Fargo TPA denies a Post-Service Claim submitted electronically, Wells Fargo TPA will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event Wells Fargo TPA denies a paper Post-Service Claim, Wells Fargo TPA will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Covered Plan Participant's responsibility to ensure that Wells Fargo Third Party Administrator receives all information determined by Wells Fargo TPA as necessary to adjudicate a Post-Service Claim. **If Wells Fargo TPA does not receive the necessary information, the claim or a portion of the claim may be denied.**

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeals procedures described in this section.

Additional Processing Information for Post-Service Claims

In any event, Wells Fargo TPA will use its best efforts to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by Wells Fargo TPA or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by Wells Fargo TPA within the applicable timeframe is subject to the loss of negotiated provider discounts through the PPO Networks.

Wells Fargo TPA will investigate any allegation of improper billing by a Provider upon receipt of written notification from the Covered Plan Participant. If Wells Fargo TPA determines that the Covered Plan Participant was billed for a service that was not actually performed, any payment amount will be adjusted and, if applicable, a refund will be requested.

Pre-Service Claims

How to File A Pre-Service Claim

The Monroe County Group Health Plan Document may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by Wells Fargo TPA of a Pre-Service Claim as that term is defined herein. In order to determine whether Wells Fargo TPA must receive a Pre-Service Claim for a particular Covered Service, please refer to the Covered Services section and other applicable sections of the Monroe County Group Health Plan Document. The Covered Plan Participant may also call the Wells Fargo TPA customer service number on the Covered Plan Participant's ID card for assistance.

Wells Fargo TPA is not required to render an opinion or make a coverage or benefit determination with respect to a service that has not actually been provided to the Covered Plan Participant unless the terms of the Monroe County Group Health Plan Document require (or condition payment upon) approval by Wells Fargo TPA for the service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

For a Pre-Service Claim Involving Urgent Care, Wells Fargo TPA will provide notice of the determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the Pre-Service Claim unless additional information is required for a coverage decision. If additional information is necessary to make a

determination, Wells Fargo TPA will provide notice within 24 hours of: 1) the need for additional information; 2) the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) the date that Wells Fargo TPA reasonably expects to provide notice of the decision. If Wells Fargo TPA requests additional information, Wells Fargo TPA must receive it within 48 hours of the request. Wells Fargo TPA will provide notice of the decision on a Covered Plan Participant's Pre-Service Claim within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period that was afforded to provide the specified additional information as described above.

Benefit Determinations on Pre-Service Claims That Do Not Involve Urgent Care

Wells Fargo TPA will provide notice of a decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. Wells Fargo TPA may extend this 15-day determination period one time for up to an additional 15 days. If such an extension is necessary, Wells Fargo TPA will provide notice of the extension and reasons for it. Wells Fargo TPA will use its best efforts to provide notification of the decision on the Covered Plan Participant's Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by Wells Fargo TPA.

If additional information is necessary to make a determination, Wells Fargo TPA will: 1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; 2) identify the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) inform the Covered Plan Participant of the date that Wells Fargo TPA reasonably expects to notify the Covered Plan Participant on the decision. If Wells Fargo TPA requests additional information, Wells Fargo TPA must receive it within 45 days of the request for the information. Wells Fargo TPA will provide notification of the decision on the Covered Plan Participant's Pre-Service Claim within 15 days of receipt of the requested additional information.

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards and appeal procedures described in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits of Services

A reduction or termination of coverage or benefits for services will be considered an Adverse Benefit Determination when:

- Wells Fargo TPA and or the Monroe County Group Health Plan Administrator has approved in writing coverage or benefits for an ongoing course of services to be provided over a period of time or a number of services to be rendered;
  and
- the reduction or termination occurs before the end of such previously approved time or number of services; and

- the reduction or termination of coverage or benefits by Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator was not due to an amendment of the Monroe County Group Health Plan Document or termination of the Covered Plan Participant's coverage as provided by the Monroe County Group Health Plan Document.

Wells Fargo TPA will notify the Covered Plan Participant of such reduction or termination in advance so that the Covered Plan Participant will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall

Wells Fargo TPA be required to provide more than a reasonable period of time within which the Covered Plan Participant may develop the appeal before Wells Fargo TPA actually terminates or reduces coverage for the services.

Requests for Extension of Services

The Covered Plan Participant's Provider may request an extension of coverage or benefits for a service beyond the approved period of time or number of approved services. If the request for an extension is for a Claim Involving Urgent Care, Wells Fargo TPA will notify the Covered Plan Participant of the approval or denial of such requested extension within 24 hours after receipt of the request, provided the request is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such services. Wells Fargo TPA will then notify the Covered Plan Participant within 24 hours if: 1) additional information is needed; or 2) the Covered Plan Participant or the Covered Plan Participant's representative failed to follow proper procedures in the request for an extension. If Wells Fargo TPA and/or Monroe County Group Health Plan Administrator request additional information, the Covered Plan Participant will have 48 hours to provide the requested information. Wells Fargo TPA may notify the Covered Plan Participant orally or in writing, unless the Covered Plan Participant or the Covered Plan Participant's representative specifically request that it be in writing. A denial of a request for extension of services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

Wells Fargo TPA will provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to the Covered Plan Participant free of charge upon request):

- the specific reason or reasons for the Adverse Benefit Determination;
- a reference to the specific Monroe County Group Health Plan Document provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- a description of any additional information that might change the determination and why that information is necessary;
- a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures;
- if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Plan Participant how to obtain the specific explanation of the scientific or clinical judgment for the determination; and
- a description of the Covered Plan Participant's appeal rights with respect to the decision.

If the Covered Plan Participant's claim is a Claim Involving Urgent Care, Wells Fargo TPA may notify the Covered Plan Participant orally within the proper timeframes, provided Wells Fargo TPA follows-up with a written or electronic notification meeting the requirements of this subsection no later than two (2) days after the oral notification.

How to Appeal an Adverse Benefit Determination

The Covered Plan Participant, or a representative designated by the Covered Plan Participant in writing, has the right to appeal an Adverse Benefit Determination. Wells Fargo TPA will review the Covered Plan Participant's appeal through the review process described below. The Covered Plan Participant's appeal must be submitted in writing to Wells Fargo TPA within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require the Covered Plan Participant to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

- Wells Fargo TPA must receive the Covered Plan Participant's appeal of an Adverse Benefit Determination in person or in writing;

- The Covered Plan Participant may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;

- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, the Covered Plan Participant may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Monroe County Group Health Plan Document to the Covered Plan Participant's medical circumstances:

- During the review process, the services in question will be reviewed without regard to the decision reached in the initial determination;

- Wells Fargo TPA may consult with appropriate Physicians, as necessary;

- An independent medical consultant who reviews a Covered Plan Participant's Adverse Benefit Determination on behalf of Wells Fargo Third Party Administrator will be identified upon request; and

- If the Covered Plan Participant's claim is a Claim Involving Urgent Care, the Covered Plan Participant may request an expedited appeal orally or in writing in which case all necessary information on review may be transmitted between the Covered Plan Participant and Wells Fargo TPA by telephone, facsimile or other available expeditious method.

<u>Timing of Appeal Review on Adverse Benefit Determinations by Wells Fargo TPA</u>

Wells Fargo TPA will review a Covered Plan Participant's appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims – within 30 days of the receipt of the Covered Plan Participant's appeal;

- Post-Service Claims – within 60 days of the receipt of the Covered Plan Participant's appeal;

- Claims Involving Urgent Care (and requests to extend concurrent care services made within 24 hours prior to the termination of the services)- within 72 hours of receipt of the Covered Plan Participant's request. If

additional information is necessary Wells Fargo TPA will notify the Covered Plan Participant within 24 hours and Wells Fargo TPA must receive the requested additional information within 48 hours of the request. After Wells Fargo TPA receives the additional information, Wells Fargo TPA will have an additional 48 hours to make a determination.

Note: The nature of a claim for services (i.e., whether it is "urgent care" or not) is judged as of the time of the benefit determination on review, not as of the time the service was initially reviewed or provided.

Submit appeals of Adverse Benefit Determinations to:

Wells Fargo Third Party Administrator
P. O. Box 366
Charleston, WV 25322

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

   In order to process claims, Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator may need certain information, including information regarding other health care coverage the Covered Plan Participant may have. The Covered Plan Participant must cooperate with the Monroe County Group Health Plan Administrator and/or Wells Fargo TPA's effort to obtain such information by, among other ways, signing any release of information form at the request of Wells Fargo TPA. Failure by the Covered Plan Participant to fully cooperate with Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator may result in a denial of the pending claim.

2. Physical Examination:

   In order to make coverage and benefit decisions, the Monroe County Group Health Plan Administrator may, at its expense, require the Covered Plan Participant to be examined by a health care Provider of the Monroe County Group Health Plan Administrator's choice as often as is reasonably necessary while a claim is pending. Failure by the Covered Plan Participant to fully cooperate with such examination shall result in a denial of the pending claim.

3. Legal Actions:

   No legal action arising out of or in connection with coverage under the Monroe County Group Health Plan Document may be brought against the Monroe County Group Health Plan Administrator within the 60-day period following receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statue of limitations.

4. Fraud, Misrepresentation or Omission in Applying for Benefits:

   Wells Fargo TPA relies on the information provided on the itemized statement and the claim form when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator may have, in denial of the claim or cancellation or rescission of the Covered Plan Participant's coverage.

5. Explanation of Benefits Form:

   All claims decisions, including denial and claims review decisions, will be communicated to the Covered Plan Participant in writing either on an explanation of benefits form or some other written correspondence. This form may indicate:

   a) the specific reason or reasons for the Adverse Benefit Determination;
   b) reference to the specific Monroe County Group Health Plan Document provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination:
   c) a description of any additional information that would change the initial determination and why that information is necessary;
   d) a description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
   e) if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling the Covered Plan Participant how they can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond the Control of Wells Fargo TPA:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of Wells Fargo TPA, results in facilities, personnel or financial resources of Wells Fargo TPA being unable to process claims for Covered Services, Wells Fargo TPA will have no liability or obligation for any delay in payment of claims for Covered Services, except that Wells Fargo TPA will make a good faith effort to make payment for such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of Wells Fargo TPA if Wells Fargo TPA cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section 19 - General Provisions

Access to Information

Wells Fargo TPA and Monroe County Group Health Plan Administrator have the right to receive, from a Covered Plan Participant or Covered Plan Participant's Provider rendering Service to a Covered Plan Participant information that is reasonably necessary, as determined by Wells Fargo TPA and the Monroe County Group Health Plan Administrator, in order to administer the coverage and benefits provided, subject to all applicable confidentiality requirements listed below. By accepting coverage, Covered Plan Participants authorize every heath care Provider who renders Services to a Covered Plan Participant to disclose to Wells Fargo TPA and the Monroe County Group Health Plan Administrator or to affiliated entities, upon request, all facts, records, and reports pertaining to the Covered Plan Participant's care, treatment, and physical or mental Condition, and to permit Wells Fargo TPA and/or the Monroe County Group Health Plan Administrator to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and benefits, Wells Fargo TPA or the Monroe County Group Health Plan Administrator may, without consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to any person covered under the Monroe County Group Health Plan Document or applicant for enrollment which Wells Fargo TPA or the Monroe County Group Health Plan Administrator deem to be necessary.

Right to Recovery

Whenever the Monroe County Group Health Plan has made payments in excess of the maximum provided under the Monroe County Group Health Plan Document, Wells Fargo TPA or the Monroe County Group Health Plan Administrator will have the right to recover any such payments, to the extent of such excess, from a Covered Plan Participant or any person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under the Monroe County Group Health Plan Document shall be deemed to have been modified and shall be interpreted so as to comply with applicable state and federal laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for the Monroe County Group Health Plan to administer coverage and benefits, specific medical information concerning a Covered Plan Participant, received by Providers, shall be kept confidential by the Monroe County Group Health Plan Administrator in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including Wells Fargo TPA's quality assurance. Additionally, Wells Fargo TPA and/or Monroe County Group Health Plan Administrator may disclose such information to entities affiliated with it or other persons or entities it utilizes to assist in providing coverage, benefits or services under the Monroe County Group Health Plan Document. Further, any documents or information which are

properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

Wells Fargo TPA's arrangements with a Provider may require that it release certain claims and medical information about Covered Plan Participant s covered under the Monroe County Group Health Plan Document to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, the Covered Plan Participant hereby authorizes Wells Fargo TPA to release to Providers claims information, including related medical information, pertaining to a Covered Plan Participant in order for any such Provider to evaluate a Covered Plan Participant's financial responsibility under the Monroe County Group Health Plan Document.

Benefit Booklet

All Covered Plan Participant's have been provided with the Monroe County Group Health Plan Document and an Identification Card(s) as evidence of coverage under the Monroe County Group Health Plan.

Cooperation Required of All Covered Plan Participants

All Covered Plan Participants must cooperate with Wells Fargo TPA and the Monroe County Group Health Plan Administrator, and must execute and submit any consents, releases, assignments, and other documents requested in order to administer, and exercise any rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause (See the Termination of an Individual's Coverage for Cause subsection in the Termination of Coverage section).

Non-Waiver of Defaults

Any failure by Wells Fargo TPA or the Monroe County Group Health Plan Administrator at any time, or from time to time, to enforce or to require in strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect Wells Fargo TPA's or Monroe County Group Health Plan Administrator's right at any time to enforce any terms or conditions under the Monroe County Group Health Plan Document.

Notices

Any notice required or permitted hereunder will be deemed given if hand delivered or if mailed by United States Mail, postage prepaid, and addressed as listed below. Such notice will be deemed effective as of the date delivered or so deposited in the mail.

To Wells Fargo Third Party Administrator: The address printed on the Identification Card.

To a Covered Plan Participant: The latest address provided by the Covered Plan Participant or to the address on the latest Enrollment Form actually delivered to the Benefits Office.

All Covered Plan Participants must notify the Monroe County Group Health Plan Administrator (Benefits Office) immediately of any address change.

If to Monroe County Group Health Plan Administrator: To the address provided in the General Plan Information Section.

Obligations Upon Termination

Upon termination of a Covered Plan Participant's coverage for any reason, there will be no further liability or responsibility to the Covered Plan Participant under the Monroe County Group Health Plan, except as specifically described herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of the Monroe County Group Health Plan Document.

Florida Agency for Health Care Administration Performance Data

The performance outcome and financial data published by the Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute, located at the web site address: http://ahca.myflorida.com/SCHS/index.shtml or www.FloridaHealthFinder.gov

Third Party Beneficiary

The terms and provisions of the Monroe County Group Health Plan Document shall be binding solely upon, and inure solely to the benefit of, Monroe County Board of County Commissioners and individuals covered under the terms of the Monroe County Group Health Plan Document, and no other person shall have any rights, interest or claims there under, or under the Monroe County Group Health Plan Document, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise.

Notification of Plan Changes

Any proposed change to the Plan that would constitute a material reduction in benefits or change in cost to current Covered Plan Participants that will be presented to the BOCC will be preceded by a two week written notice to the affected Covered Plan Participants.

Section 20 - Health Insurance Portability and Accountability Act (HIPAA)

Use and Disclosure of Protected Health Information (PHI)

The Plan Administrator, as the sponsor of the Monroe County Health Insurance Plan "Sponsor", will use and disclose protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Sponsor will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The provisions of this section (and other provisions of the Plan relating to HIPAA privacy rules) shall be effective on April 14, 2003, or such later date as may be provided by federal law or regulation.

Use and Disclosure of PHI for Treatment, Payment and Operations

The Sponsor may, without the consent or authorization of the Covered Plan Participant, use and disclose PHI for health care treatment, health care payment, and health care operations, and other uses or disclosures to the full extent permitted by regulations promulgated by the Secretary of Health and Human Services to implement HIPAA, subject to more stringent state privacy laws which do not conflict with HIPAA (if any).

The Sponsor may also disclose PHI to such other persons and for such other purposes when authorized by the Covered Plan Participant on a form and in a manner provided for in regulations promulgated by the Secretary of Health and Human Services to implement HIPAA.

The Sponsor may also disclose summary health information to the BOCC or the Employer if requested for the purpose of obtaining bids from health plans for providing health insurance coverage, or for modifying, amending or terminating the Plan. The Sponsor may also disclose information on whether the individual is participating in the group health plan.

With Respect to PHI, the Plan Agrees to Certain Conditions

The Sponsor agrees to:

1. Not use of further disclose PHI other than as permitted or required by the Plan document or as required by law;

2. Ensure that any agents, including a subcontractor, to whom the Sponsor provides PHI, agrees to the same restrictions and conditions that apply to the Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by the Covered Plan Participant;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the BOCC unless authorized by the Covered Plan Participant;

5. Make PHI available to a Covered Plan Participant in accordance with HIPAA's access requirements;

6. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

7. Make available the information required to provide an accounting of disclosures;

8. Make internal practices, books and records relating to the use and disclosure of PHI available to the HHS secretary for the purposes of determining the Plan's compliance with HIPAA; and

9. If feasible, return or destroy all PHI received that the BOCC still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction if not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Section 21 - Definitions

The following definitions are used in the Monroe County Group Health Plan Document. Other definitions may be found in the particular section or subsection where they are used.

Accident means an unintentional, unexpected event, other than the acute onset of a bodily infirmity or disease, which results in traumatic injury. This term does not include injuries caused by surgery or treatment for disease or illness.

Accidental Dental Injury means an injury to sound natural teeth (not previously compromised by decay) caused by a sudden, unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or injuries to natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.

Active Work means active full time performance by an Eligible Employee of all customary duties of his or her occupation at the Employer location or another location of business to which the Employer requires the Eligible Employee to travel. An Eligible Employee shall be deemed "Active at Work" on each day of regular paid vacation, and on a regular nonworking day on which the Eligible Employee is not disabled, provided the Eligible Employee was actively at work on the last preceding working day.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Monroe County Group Health Plan Document with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in this section, shall also constitute an Adverse Benefit Determination.

Allowed Amount means the maximum amount upon which payment will be based for Covered Services established in accordance with the applicable agreements between the Monroe County Group Health Plan and the PPO Networks. The Allowed Amount may be changed at any time without notice to Covered Plan Participant or their consent.

Ambulance means a ground or water vehicle, airplane or helicopter properly licensed pursuant to Chapter 401 of the *Florida Statutes*, or a similar applicable law in another state intended to be used for transportation of sick or injured persons requiring or likely to require medical attention during transport.

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the *Florida Statutes*, or similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day.

Artificial Insemination (AI) means a medical procedure in which sperm is placed into the female reproductive tract by a qualified health care provider for the purpose of producing a pregnancy.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the *Florida Statutes*, or a similar applicable law or another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-

prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs.

Calendar Year begins January 1st and ends December 31st.

Cardiac Therapy means Health Care Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery.

Certified Nurse Midwife means a person who is licensed pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state, as an advanced registered nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

Certified Registered Nurse Anesthetist means a person who is a properly licensed nurse who is certified advanced registered nurse practitioner within the nurse anesthetist category pursuant to Chapter 464 of the *Florida Statutes*, or a similar applicable law of another state.

Claim Involving Urgent Care means any request or application for coverage or benefits for medical care or treatment that has not yet been provided with respect to which the application of time periods for making non-urgent care benefit determinations: (1) could seriously jeopardize the life or health or a Covered Plan Participant's ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of the Covered Plan Participant's Condition, would subject the Covered Plan Participant to severe pain that cannot be adequately managed without the proposed Services being rendered.

Claims Administrator means the individual or entity that processes claims, provides certain financial services, provides reports and makes initial benefit determinations subject to the Monroe County Group Health Plan Document. It does not fund or insure claim payments or bear any financial risk with regard to The Plan's expenses. Currently, the Claims Administrator is Wells Fargo Third Party Administrator. The Plan has the discretion to change its Claims Administrator at any time.

Coinsurance means the Covered Plan Participant's share of health care expenses for Covered Services. After the Deductible requirement is met, a percentage of the Allowed Amount will be paid for Covered Services, as listed in the Schedule of Benefits. This percentage is the Coinsurance for which the Covered Plan Participant is responsible

Concurrent Care Decision means a decision by Wells Fargo Third Party Administrator to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized in writing coverage, benefits or payment for that course of treatment or number of treatments.

Condition means a disease, illness, ailment, injury, or pregnancy.

Covered Employee/Retiree means an Eligible Employee or an Eligible Retiree who is enrolled, and actually covered, under the Monroe County Group Health Plan Document.

Covered Plan Participant means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Monroe County Group Health Plan Document.

Covered Services means those Health Care Services which meet the criteria listed in the "Covered Services" section.

Creditable Coverage means health care you have had in the past, such as coverage under a group health plan (including COBRA continuation coverage), an HMO, an individual health insurance policy, Medicare or Medicaid, and this prior coverage was not interrupted by a break in coverage of 63 days or more. The time period of this prior coverage must be applied toward any pre-existing condition exclusion imposed by the Plan.

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered or administered by a home care giver. Custodial Care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is Custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services that are the Covered Plan Participants responsibility. The term, Deductible, does not include any amounts in excess of the Allowed Amount, or any Coinsurance/Copay amounts, if applicable, that are the responsibility of the Covered Plan Participant.

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, individual is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the individual at the minimum.

Diabetes Educator means a person who is properly certified pursuant to Florida law, or a similar applicable law of another state, to supervise diabetes outpatient self-management training and educational services.

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling or diabetes outpatient self-management services.

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

Effective Date means, with respect to individuals covered under the Monroe County Group Health Plan Document, 12:01 a.m. on the date Monroe County Group Health Plan Administrator specifies that the coverage will commence as further described in the "Enrollment & Effective Date of Coverage" section of the Monroe County Group Health Plan Document.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependent(s) subsection of the "Eligibility for Coverage" section in the Monroe County Group Health Plan Document, and is eligible to enroll as a Covered Plan Participant.

Refer to the "Eligibility for Coverage" section for limits on eligibility.

Eligible Employee/Retiree means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Covered Employee subsection of the Eligibility for Coverage section in the Monroe County Group Health Plan Document and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Plan Participant until such individual has actually enrolled with, and been accepted for coverage as a Covered Plan Participant by the Monroe County Group Health Plan Administrator.

Employer means the Monroe County Board of County Commissioners; Clerk of the Circuit Court; Land Authority; Property Appraiser; Sheriff's Office; Supervisor of Elections; Tax Collector.

Endorsement means an amendment to the Monroe County Group Health Plan Document.

Experimental or Investigational means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by Wells Fargo TPA or the Monroe County Group Health Plan Administrator:

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration of the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to a Covered Plan Participant; or

2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or

3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or

4. creditable scientific shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of the Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or

5. creditable scientific shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or

6. creditable scientific shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using Generally Accepted Standards of Medical Practice; or

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or

8. such evaluation, treatment; therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific" shall mean (as determined by Wells Fargo TPA or Monroe County Group Health Plan Administrator):

1. records maintained by Physicians or Hospitals rendering care or treatment to a Covered Plan Participant or other patients with the same or similar Condition;

2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

4. the written protocol or protocols rely upon by the treating Physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy or device;

5. the written informed consent used by the treating Physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

Note: Health Care Services which are determined by Wells Fargo TPA or the Monroe County Group Health Plan Administrator to be Experimental or Investigational are excluded (see the "Covered Services" section)in determining whether a Health Care Service is Experimental or Investigational. Wells Fargo TPA or Monroe County Group Health Plan Administrator may also rely on the predominant opinion among experts, as expressed in published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

Foster Child means a person who is placed in a Covered Plan Participant's residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state's applicable laws.

Generally Accepted Standards of Medical Practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Gestational Surrogate means a woman, regardless of age, who contract, orally or in writing, to become pregnant by means of assisted reproductive technology without the use of an egg from her body.

Gestational Surrogacy Contract or Arrangement means an oral or written agreement, regardless of the state or jurisdiction where executed, between the Gestational surrogate and the intended parent or parents.

Health Care Services or Services includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of, Providers.

Home Health Agency means a properly licensed agency or organization which provides health services in the home pursuant to Chapter 400 of the *Florida Statutes*, or similar applicable law of another state.

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or indirectly through) a Home Health Agency in the Covered Plan Participant's home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

Hospice means a public agency or private organization which is duly licensed by the State of Florida under applicable law, or a similar applicable law of another state, to provide hospice services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the *Florida Statues*, or a similar applicable law of another state, that: offers services which are more intensive than those required for room, board, personal services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory services, diagnostic x-ray services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility, a Substance Abuse Facility; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, the payment for these services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Identification (ID) Card means the card(s) issued to Covered Plan Participants under the Monroe County Group Health Plan. The card is not transferable to another person. Possession of such card in no way guarantees that a particular individual is eligible for, or covered under the Monroe County Group Health Plan.

In-Network means, when used in reference to Covered Services, the level of benefits payable to an In-Network Provider as designated on the Schedule of Benefits under the heading "In-Network". Otherwise, In-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is an In-Network Provider under the terms of the Monroe County Group Health Plan Document.

Licensed Practical Nurse means a person properly licensed to practice practical nursing pursuant to Chapter 464 of the *Florida Statutes,* or similar applicable law of another state.

Massage Therapist means a person properly licensed to practice Massage, pursuant to Chapter 480 of the *Florida Statutes*, or a similar applicable law of another state.

Mastectomy means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Medical Literature means scientific studies published in a United States peer-reviewed national professional journal.

Medically Necessary or **Medical Necessity** means that, with respect to a Health Care Service, a Physician, exercising prudent clinical judgment, provided the Health Care Service to the Covered Plan Participant for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that the Health Care Service was:

1. in accordance with General Accepted Standards of Medical Practice;

2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Plan Participant's illness, injury or disease; and

3. not primarily for the Covered Plan Participants convenience, or that of the Covered Plan Participant's Physician or other health care Provider, and not more costly that an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Plan Participant's illness.

Medicare means the federal health insurance provided under Title XVIII of the Social Security Act and all amendments thereto.

Mental Health Professional means a person properly licensed to provided mental health Services, pursuant to Chapter 491 of the *Florida Statutes*, or a similar applicable law of another state. This professional may be a clinical social worker, mental health counselor or marriage and family therapist. A Mental Health Professional does not include members of any religious denomination who provide counseling services.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the Internal Classification of Disease, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

Midwife means a person properly licensed to practice midwifery pursuant to Chapter 467 of the *Florida Statues*, or a similar applicable law of another state.

Morbid Obesity means a condition diagnosed by a Physician in which the patient who is over 18 years old and has completed bone growth meets one (1) or more of the following criteria:

- A body mass index (BMI) exceeds forty (40);

- A body mass index is greater than thirty-five (35) in conjunction with severe co-morbidities that are likely to reduce life expectancy (e.g., cardiopulmonary complications, severe diabetes, severe sleep apnea; medically refractory hypertension);

- A body weight of approximately 100 lbs. over ideal weight as provided in the Metropolitan Life and Weight table.

Occupational Therapist means a person properly licensed to practice Occupational Therapy as pursuant to Chapter 468 of the *Florida Statutes*, or a similar applicable law of another state.

Occupational Therapy means a treatment that follows an illness or injury and is designed to help a patient learn to use a newly restored or previously impaired function.

Orthotic Device means any rigid or semi-rigid device needed to support a weak or deformed body part or restrict or eliminate body movement.

Out-of-Network means, when used in reference to Covered Services, the level of benefits payable to an Out-of-Network Provider as designated on the Schedule of Benefits under the heading "Out-of-Network". Otherwise, Out-of-Network means, when used in reference to a Provider, that, at the time Covered Services are rendered, the Provider is not an In-Network Provider under the terms of the Monroe County Group Health Plan Document.

Outpatient Facility means any licensed facility which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet Wells Fargo Third Party Administrator criteria for eligibility as an Outpatient Facility. The term Outpatient Facility, as used herein, shall not include any the office of any Physician, Midwife, Physical Therapist, Occupational Therapist; any Hospital, including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, *Florida Administrative Code* or the similar law or laws of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, physical therapy, biofeedback, and/or counseling. Pain rehabilitation programs are programs featuring multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

Physical Therapist means a person properly licensed to practice Physical Therapy pursuant to Chapter 486 of the *Florida Statutes*, or a similar applicable law of another state.

Physician means any individual who is properly licensed by the state of Florida, or a similar applicable law of another state, as a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.)

Physician Assistant means a person properly licensed pursuant to Chapter 458 of the *Florida Statutes*, or a similar applicable law of another state to perform medical services delegated by the supervising Physician.

Plan means the Monroe County Group Health Plan Document.

Plan Administrator means the Monroe County Board of County Commissioners.

Prosthetic Device means a device designed or manufactured by a person or entity that is properly licensed, if applicable, under Florida law, or a similar applicable law of another state, to provide services consisting of the design and fabrication of medical devices such as braces, splints, and artificial limbs prescribed by a Physician.

Provider means any facility, person or entity recognized for payment by Wells Fargo Third Party Administrator under the Monroe County Group Health Plan Document.

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490 of the *Florida Statutes*, or a similar applicable law of another state.

Registered Domestic Partner means a person who has established a Domestic Partnership with a Covered Plan Participant according to Monroe County Board of County Commissioners Resolution No. 081-1998.

Registered Nurse means a person properly licensed to practice professional nursing pursuant to Chapter 464 of the *Florida Statutes,* or a similar applicable law of another state.

Skilled Nursing Facility means an institution or part thereof which meets Wells Fargo Third Party Administrator's criteria for eligibility as a Skilled Nursing Facility and which: 1) is licensed as a Skilled Nursing Facility by the state of Florida or a similar applicable law of another state; and 2) is accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by Wells Fargo Third Party Administrator.

Speech Therapist means a person properly licensed to practice Speech Therapy pursuant to Chapter 468 of the *Florida Statutes*, or similar applicable law of another state.

Substance Abuse Facility means a facility properly licensed under Florida law, or a similar applicable law of another state, to provide necessary care and treatment for Substance Dependency. For the purposes of the Monroe County Group Health Plan Document a Substance Abuse Facility is not a Hospital or a Psychiatric Facility, as defined herein.

Substance Dependency means a Condition where a person's alcohol or drug use injures his or her health; interferes with his or her social or economic functioning; or causes the individual to lose self-control.

Urgent Care means care offered at a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, to where to obtain such Services when the Urgent Care center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

For the purposes of the Monroe County Group Health Plan Document, an Urgent Care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

Waiting Period means the length of time established by the Monroe County Group Health Plan Document which must be met by an individual before that individual becomes eligible for coverage under the Monroe County Group Health Plan Document.

Board of County Commissioners

Monroe County Group Health Plan

Each provision, each benefit, each page in the Plan Document for which the pages attached have been reviewed and approved by the undersigned.

This Plan Document is Effective January 1, 2010, except as otherwise noted.

Name: Board of County Commissioners – Monroe County

Approved by: Sylvia J. Murphy

Date: MAR 1 7 2010